Life Opportunities Trust

Life Opportunities Trust - 329 Martindale Road

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The unannounced inspection took place on 4 and 6 December 2018.

The last comprehensive inspection took place on 15 June 2016. At this inspection we rated the service requires improvement for the key question, 'is the service well-led?' and found breaches of the Health and Social Care Act 2008 (Registration) Regulations 2009 because the provider did not always notify us about significant events. We carried out a focussed inspection on 2 March 2017. At this inspection we found that the provider had made improvements but these improvements had not been consistent and we continued to rate the key question, 'is the service well-led?' as requires improvement. The overall rating of the service was good.

Life Opportunities Trust - 329 Martindale Road is a care home situated in a residential street in Hounslow. 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.

People using the service had multiple or complex needs such as profound learning and physical disabilities and were living with additional conditions, including epilepsy and dementia. People required varying degrees of support from staff throughout the day, ranging from verbal prompting and intensive one-to-one support to interact with others, to full assistance to eat and one or two staff to support them with personal care and to use their wheelchairs. People had very limited or no ability to verbally communicate with others. The service was managed by the Life Opportunities Trust, a registered charity which also ran six other care homes and one personal care service for people with learning disabilities in north-west London and Hertfordshire.

There was a registered manager who has been in post since the last 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.

The care service has not 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 were not supported to live a good and meaningful lives just as other citizens expect to.

Staff did not always treat people with dignity and respect. Some of the staff's approaches were not always appropriate and demonstrated a lack of empathy for people using the service. Some of the staff interactions with people were task-based and communication was sometimes limited to a word or two at a time. Staff did not respond to people appropriately when people communicated with them.

People's independence was not always respected and promoted.

The way in which care was provided was not always person centred and did not reflect nationally recognised good practice guidance. People had some opportunities to access the community and some planned activities, but did not regularly benefit from meaningful activities or positive interactions with the staff team while they were at home.

Risks to people's safety and wellbeing were not always being reasonably mitigated.

The service was not supporting people in line with the principles of the Mental Capacity Act 2005.

Quality assurance and audit systems had not always been effective as they had not identified or addressed issues of the quality and safety of the service.

The provider did not display a CQC rating for this service on its website as required by law.

The provider did not have an effective management process for ensuring that it submitted information to the CQC when required in that they had not completed and sent the Provider Information Return in a timely manner when this was requested.

People's care and risk management plans set out what their care needs were and how these should be met. They also prescribed a daily routine for each person. The plans included person-centred information about individuals' personal histories, their likes and dislikes and preferences, and end of life care planning.

The environment was clean and appropriately maintained and there were regular environmental checks. The provider had updated communal areas and some furnishing and had plans to replace flooring. The provider made sure equipment was safe to use. The staff followed procedures to minimise the risks of infection.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were recruited to work at the service. There was a programme of training for staff to enable them to carry out their roles. The staff felt supported by the manager and told us they had the training and support they needed.

There were enough staff deployed to keep people safe, but people sometimes had to wait for care and support. We have made a recommendation regarding the provider determining appropriate staffing levels to meet people's assessed needs.

The service was supporting people to have their healthcare needs met.

The provider had systems in place to ensure they responded appropriately to allegations of harm and abuse. They were working in partnership with external agencies and stakeholders.

The provider had systems for handling complaints and responding to incidents and accidents. We have made a recommendation about the service's complaints procedures.

We found the service to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding person centred care, dignity and respect, safe care and treatment, safeguarding people who use the service from abuse and improper treatment, and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

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.

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

Some aspects of the service were not safe.

People were not receiving care and support in a way that prevented them from experiencing avoidable risks of harm.

Medicines were not always being safely managed.

There were enough staff deployed to keep people safe, but people sometimes had to wait for care and support.

People were protected by the prevention and control of infection.

The environment and equipment were safely maintained and kept clean.

Safe staff recruitment procedures were in place and being followed.

There were systems to learn and make improvements when things went wrong.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People were not always supported in line with the principles of the Mental Capacity Act.

Staff were supported and provided with training to enable them to carry out their roles.

People's nutritional and health needs were met.

Is the service caring?

Inadequate

The service was not caring.

The staff did not speak with people with kindness and respect. Their interactions were not always appropriate, demonstrated a lack of empathy, were task based and limited to a few words at a

time.

People were not always treated with dignity and respect.

People's independence was not always respected and promoted.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People had opportunities to access the community and some planned activities, but did not regularly benefit from meaningful activities or interactions with the staff team which offered stimulation or met their interests while they were at home.

People were supported to access appropriate end of life care when needed.

The provider had a system for handling and responding to complaints.

Is the service well-led?

Inadequate

Some aspects of the service were not well-led.

The service's systems for monitoring the quality and safety of the service were not operated effectively.

The service was working in partnership with other agencies to support people's health and well-being.

The provider had not provided information to the CQC as required and did not display the service's most recent inspection rating on its website.

Life Opportunities Trust - 329 Martindale Road

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.

The unannounced inspection took place on 4 and 6 December 2018. This was a comprehensive inspection conducted by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is information we require the provider to send us to give some key information about the service, what the service does well and improvements they plan to make. The provider did not return the completed PIR even though we granted their request for additional time to complete this. We took this into account when we made the judgements in this report.

To help plan our inspection, we reviewed the information we already held about the provider. This included notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also looked at the provider's own website and other public information about the service available on the internet.

During the inspection we met all five people who lived at the service. They had complex needs and could not describe to us how they felt about living at the service. We observed how they were cared for and treated. Our observations included a Short Observational Framework Inspection (SOFI) during the visit. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We also observed the interactions between staff and people using the service throughout the inspection visits. We met with the registered manager, the team leader, five support staff and a visiting healthcare

professional. We looked at the care records for two people, training and support records for three members of staff, records of quality monitoring and checks on the service, meeting minutes, daily shift plans and daily records of people's activities. We looked at how medicines were being managed and considered the general environment.

Following the inspection, we spoke with one relative of people who lived at the service and nine community professionals who have worked with the service.

Requires Improvement

Is the service safe?

Our findings

Staff did not always support people to eat and drink in a safe way. Some people needed full assistance from staff to eat and others were at risk of choking due to issues with swallowing. During our inspection we observed staff supporting a person to eat while they were very sleepy. The staff member supporting this person did not ensure they were fully awake before they offered them food and drink. They also moved the person's articulated chair into a reclining position immediately after the person had finished eating. These practices increased the risk of people choking. We notified the registered manager of this so that they could take immediate action to address this, which they said they would do.

The risk assessments for one person who was at risk of choking included the action that the support staff had regular training on dysphagia (difficulty to swallow). The service's training plan and records indicated that staff had not had this training. Information for staff about dysphagia did not reflect current recognised guidance. This meant that the provider had not taken reasonable steps to ensure people were being protected from the risks associated with dysphagia.

On the morning of the inspection visit on 4 December 2018 we found that some cleaning chemicals and other potentially hazardous materials were not stored securely and this presented a risk to some people using the service. For example, we found a large container of washing detergent in the main corridor downstairs, detergent stored in the unlocked laundry room and a cupboard in the kitchen that was being used for the storage of cleaning products was kept unlocked for the duration of our visit. We also found that the door to one of the vacant bedrooms was propped open and there were tins of paint accessible to people. The service's risk assessment for the storage of potentially hazardous materials indicated that using lockable cupboards would reduce the risk of harm to people using the service and this was not being put into practice.

There was a large rip in the carpet inside the sensory room. This presented a potential tripping hazard and we informed the registered manager, so they could make this area safe.

On the inspection visit of 6 December 2018 a large window was open on the staircase about halfway from the ground to the first floors. The window was situated approximately one metre from the floor. The window did not have any restrictors in place. The registered manager informed us that a person who would frequently walk around the house independently sometimes came up the stairs. There were no risk assessments in place to address the risk of a person from accessing the window and falling from height. We notified the registered manager of this so that they could take action to address this, which they said they would do.

The provider did not always ensure the safe and proper management of medicines. Staff administering medicines signed administration records, however we observed a member of staff signed to indicate that they had administered medicines before these were then taken to a person to take. This is not best practice as it does not accurately record that a person has actually taken their prescribed medicines.
Some medicines records and practices had not been updated to reflect changes in people's prescriptions.

We found that one medicine that was no longer prescribed for a person was still stored in the controlled drugs cupboard and the records for this were not up to date. We discussed this with the registered manager who agreed that the medicine needed to be removed from the service. Also, we noted that recording in the controlled drugs register was not always clear and there were not always two staff signatures in place as required by the provider's policy and medicines management. This meant that the service could not easily determine the quantities of medicines that were being stored and available to people. The registered manager told us that they had recently purchased a new register in a different format that would improve the clarity of this record keeping.

The above issues meant that risks to people's safety and wellbeing were not always being identified and where these were identified these were not always being reasonably mitigated.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People received their medicines as prescribed and these were administered in accordance with the prescriber's instructions. The dispensing pharmacist told us that they had no concerns regarding medicines support at the home. There were protocols in place for the administration of PRN (as required) medicines so staff were clear when to administer these medicines.
The staff recorded the amount of medicines being received and returned by the service. These records were audited regularly. The provider had identified medicines administration errors and responded to these appropriately. Medicines were stored securely and appropriately and boxed medicines were audited on weekly basis. The local clinical commissioning group had reviewed the medicines support practices within the last six months and we saw that the service had acted on the review's recommendations.

The service had assessed the risk of people choking and had referred people to healthcare professionals for support and guidance about how to manage the risk. Regarding one person living at the service they visited, one healthcare professional told that they were "happy with the eating support at mealtimes" and that "staff are very good at following the eating and drinking guidelines".
People's care plans included risk management plans that identified areas of risk to people's safety and the actions required to minimise those risks. The plans identified areas such as living with epilepsy, moving and handling support, using the service's accessible vehicle and accessing the community. We saw that staff were signing these plans to show that they had read and understood them

There were procedures to be followed in the event of different emergency situations, including fire. Each person living at the service had an individual personal evacuation plans in place that had been reviewed and was up to date. There were appropriate fire safety systems in place that were checked regularly.

The staff team used hoists and adjustable beds to support people with mobility issues. The equipment was appropriate to the needs of the people living at the service and it was maintained and regularly serviced.

People were protected by the prevention and control of infection. Staff wore protective clothing that was available to them, such as gloves and aprons, when supporting people and disposed of these appropriately. There was information about infection control in the kitchen and hand gel was available in the corridors. Representatives of people who lived at the home told us that they thought the cleanliness of the home had improved over recent years. The management team undertook regular checks on cleanliness and there was a cleaning routine in place at the service that staff were following. Staff checked and recorded food and fridge temperatures and these records were monitored by the provider.

The staff team completed monthly health and safety checks. These included checks of water temperatures and the home environment. The registered manager and the provider also periodically audited the

cleanliness and health and safety issues. Records of these checks and audits indicated that issues were being noted and addressed.

The provider carried out appropriate recruitment checks to ensure staff were suitable to work at the service. These included references from previous employers and information about any criminal records from the Disclosure and Barring Service. The registered manager told us that they interviewed all applicants. There were two staff vacancies at the time of our inspection and the registered manager told us that they were looking to recruit new staff. A prospective applicant visited the service during our inspection. The staff team worked some overtime and the provider sourced temporary staff from a recruitment agency where there was a shortage of staff. The registered manager told us they sourced the same familiar staff members.

The registered manager told us that currently there were three support staff on duty in the mornings, two on duty in the afternoons and evenings, and one waking and one sleep-in staff working overnight. This had been reduced from three staff being on duty in the afternoons and evenings since a person who used to live at the service had passed away several months before our inspection. We reviewed the staffing rotas for the month prior to our inspection, which confirmed these staffing ratios. This meant that there were sufficient numbers of staff to support people to stay safe. Some staff we spoke with told us that if a person was supported to go out in the afternoon then some people had to wait for personal care as there was not enough staff available.

The management team told us that there was sufficient staffing to meet people's needs and that they were available in the morning or afternoon during the week to provide additional support if required. The management team also told us that some extra staff hours would be provided if a specific activity was arranged outside of the home for someone. The staffing rotas for the month prior to our inspection indicated that an extra staff shift had only been provided on one occasion during that period. The registered manager could not give us information on how the staffing levels were determined and effectively deployed to meet people's assessed care and support needs at all times. The registered manager said they would discuss this with their managers.

We recommend that the provider seek and follow best practice guidance on determining appropriate staffing levels to meet people's assessed needs.

The staff had received training in adult safeguarding and the staff we spoke with knew how to raise safeguarding concerns. Safeguarding was discussed with staff in team meetings and individual supervision sessions with the registered manager. There had not been any reported safeguarding concerns at the service for the last 12 months. The provider had procedures for safeguarding people from the risk of abuse. There was information about these and reporting abuse on display at the service. There was easy read information about safeguarding adults as well. We noted that some of this information directed the reporting of concerns to a local authority that was different to the authority in whose area the home was situated. This meant that people were not always given clear information about the statutory agencies to whom they could report safeguarding concerns.

The provider handled personal money on behalf of people using the service as they did not have the mental capacity to manage this themselves. There was a suitable recording system in place to document the safe handling of people's money.

The provider had procedures for investigating and responding to complaints, incidents, accidents and safeguarding concerns so that these could be learnt from. Incident records demonstrated that the service responded to these incidents appropriately.

Requires Improvement

Is the service effective?

Our findings

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). The procedures require providers to submit applications to deprive someone of their liberty to a 'supervisory body' authority.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found a number of restrictions on people where their rights were not being upheld and the provider could not demonstrate that these were in the best interests of the people. During the inspection the staff moved people in wheelchairs around the service without checking that this was what they wanted. We witnessed the staff assisting two people to eat, even though both people were able to, and had been, eating independently. The staff did this because they wanted people to eat more quickly. One person verbally protested this, however the staff repeatedly tried to intervene and physically assist the person when they had said they did not want this.

On the morning of 6 December staff placed aprons on two people then secured these in place at the dining table by putting items such as a place mats, bowls and cups on top of them. Neither person could independently remove the aprons which were restricting their freedom and movement. The staff regularly checked and reapplied the items if they were moved out of place by the person's natural movements. The staff had not ensured that they received people's consent before placing the aprons on people.

The provider had made applications under the DoLS for authorisations to deprive some people of their liberty and was notifying the CQC of the outcomes of those applications as required. People were visited periodically by independent statutory advocates as part of this process and the home's staff supported these appointments. However, we found that where there were conditions on authorisations to deprive a person of their liberty these had not always been met by the service. For example, conditions required that the service work with other stakeholders to complete mental capacity assessments and record making decisions in a person's best interests in regards to securing the front door of the home, the person lacking capacity to consent to their care arrangements, and supporting the person to experience invasive physical procedures (such as blood tests and 'flu vaccinations). These requirements had not been completed. This meant that people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible.

The managements systems in the service did not support this practice because the conditions of the

deprivation of liberty had not been noted and fulfilled. We also found that where a third party, such as a friend or relative, was making decisions about a person's health and welfare or their property and financial affairs, the provider was not clear about the party's legal authority to do so. These issues meant that some people's rights were not being respected as they were not being supported in line with the principles of the Mental Capacity Act.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were being supported to eat and drink enough to maintain a balanced diet. We saw that the kitchen was well stocked with a range of quality food, including fresh meat, fruit and vegetables. There was a planned menu which was varied regularly and meals were freshly made by the staff team. Daily care records showed that people ate different food each day. One person was supported to enjoy food which reflected their cultural background. People were regularly offered and supported to have drinks and snacks that were based on their known preferences and daily records that we reviewed confirmed this. For example, one person's care plan stated that they liked pork pies and they were supported to eat one during our visit. People's weight was recorded where this was part of their planned care and this was confirmed by healthcare professionals.

Staff supported people to access healthcare services to help them maintain their health. The service worked with a multi-disciplinary team to help promote people's health. This included a GP, community nurse, a speech and language therapist, specialist epilepsy nurse, physiotherapist, dietician, psychiatrist and a pharmacist. Healthcare professionals said that the service supported people to address the particular health issues about which each professional was providing advice and instruction. For example, the GP told us that the staff "respond proactively and are always responsive".

Other comments from professionals included, "I am always contacted in plenty of time regarding visits - staff are there to support residents during treatment if necessary", and "all the advice/recommendations, I am happy to report have always been carried out effectively". One professional told us, "I am happy with the care these three clients are receiving for their neurology condition." Another commented that one person's physical health had improved: "When [the person] first moved [they] wouldn't let people go near [them], touch [them]. Now [the person] lets you stretch [their] legs. These things take time." Healthcare professionals that we spoke with told us that the service responded to changes in people's health and worked appropriately with agencies to address these.

People had health action plans in place that provided information about the person, their healthcare needs and the care and support that they required to meet those needs. Staff supported people to attend healthcare appointments and we saw that the outcomes of these were being recorded. Healthcare professionals told us, "They [the staff] always keep appointments". People had detailed Hospital Passports in place, which provided information about the person, their care needs and how they may communicate. This meant that the staff could share important information about the people who use the service with healthcare services when required.

People's rooms had been personalised to varying degrees and people had their own possessions. Various Christmas decorations had been put up around the communal areas, which appeared homely. Some walls, woodwork and carpets showed signs of general wear and tear. Representatives of people who live at the home told us that the décor and fittings in the lounge, kitchen and dining area had been improved and that they would like to see the corridor flooring renewed. The provider had identified this in its annual business plan for the service and the registered manager told us that the flooring was being replaced in the new year.

The sensory room was accessible to all the people using the service. The building had been appropriately adapted to meet the needs of people who used wheelchairs. For example, there were ceiling hoists in the accessible bathrooms, wide corridors to promote safe access and low kitchen surfaces. The registered manager was planning to fundraise money to develop an accessible sensory area in the back garden.

The registered manager explained the process for assessing potential new people to the home. This included reviewing information about the person, assessing the person's care and support needs and determining whether the service could meet those needs safely and effectively. The service had recently received a referral for one of the vacancies.

The registered manager told us that new staff completed a two-week induction when they started at the service, which included shadowing existing staff, observing how staff worked with people and reading people's care and risk management plans. Staff we spoke with confirmed that they had an induction that gave them the information they needed about supporting people at the service as well as training opportunities.

Staff we spoke with told us that they felt supported and supervised by the registered manager and team leader. There was a programme of one-to-one supervisions for staff and records showed that these were taking place throughout the year. The registered manager also operated an annual training plan for the team. This included mandatory sessions such as safeguarding adults, the management of medicines, MCA and DoLS, health & safety and moving & handling, as well as additional training to support people's needs, such as Makaton, understanding autism and dementia awareness. Staff told us that they found the training useful and when they had requested specific training this had been provided. During our inspection visit on 4 December 2018 we noted that some staff were due epilepsy training. By the end of our inspection visit on 6 December 2018 the provider had arranged for this training to take place.

Inadequate

Is the service caring?

Our findings

The staff did not always treat with people with kindness and respect. Some of the staff's approaches were not always appropriate and demonstrated a lack of empathy for people using the service. The majority of the staff interactions with people were task-based and their communication was limited to a word or two at a time. Throughout both days of our inspection, we observed a culture where the staff did not behave in a caring way and demonstrated limited understanding of the impact their behaviour may have had on the wellbeing of the people who they were supporting.

People's distress or discomfort was not always responded to appropriately. On 4 December 2018 we witnessed first one and then two members of staff attempting to support a person to put on their coat to go outside. The members of staff had not told the person what they were doing or why. When this situation appeared to become more distressing for the person, staff comments to them included, "come on, come on", "stop mucking about" and "you are making too much noise now".

On 6 December 2018, we witnessed further similar interactions between the staff and one person. The person talked to the staff asking them questions and requesting a drink. The staff response was to tell the person to hurry up with their breakfast rather than responding to the person's questions or having a meaningful conversation. At one point a staff member told the person, ''[Person] you are making too much noise now, I will move you from the dining table because [another person] is going to start screaming now.'' Shortly afterwards the staff member sat next to the person. The person said that their knee hurt. The staff member responded by saying, ''Oh for [offensive word]'s sake I didn't even touch you.''

During our inspection visits we observed staff regularly carrying out tasks without telling people what was happening or why. This included moving people in their wheelchairs around a room without warning or explanation, pushing people's wheelchairs from one room to another without speaking to the people, entering rooms or returning to the service without greeting people, and placing aprons around people's necks and fronts without speaking to them about this.

The staff supporting people at mealtimes did not offer them choices or treat them with respect. None of the staff supporting people engaged with them in a meaningful way during any of the mealtime experiences we observed. On 4 December 2018 we witnessed a person being supported for 10 minutes to have a drink and snack. The member of staff prompted the person to eat in line with eating and drinking guidelines provided by the speech and language therapist. However, this was only a functional experience as the staff member only spoke short instructions to the person, did not make eye contact with the person, and was focused on a written file in front of them.

On the morning of 6 December staff provided practical assistance to a person to eat their cereal without speaking to the person throughout the time it took them to finish their food. Other people were assisted with minimal interactions and the staff repeatedly argued with one person. The staff supporting people used spoons to collect food from people's faces and placing it back in their mouths. After one person had finished their meal staff then wiped their whole face with their apron.

People's independence was not always respected and promoted in line with national and CQC guidance for people with a learning disability, including 'Registering the right support'. On 4 December 2018 we observed one person being encouraged and supported to eat independently. However, on 6 December 2018 the same person was eating their breakfast slowly and independently when staff intervened to remove the person's cereal bowl from them and to directly feed the person instead, much more quickly. Several staff tried to encourage another person to finish their breakfast quickly so that the person could leave for a timetabled activity in the community. This included staff informing the person that they (the staff) would have to feed them and trying to take the person's drink away, with the person telling staff, "I can do it myself", "no I can do it" and "I am not a child".

We reviewed daily care logs for three people for the month prior to our inspection and did not find recorded evidence of people's independence being promoted. The logs indicated that there was some basic recording of the person's wellbeing on most days. One person's logs recorded variously: "personal care given and ate and drank very well [the person] was screaming and shouting this PM later settled", "woke up and started crying - staff checked on [the person] and asked [the person] to stop crying but [the person] continued to and later stopped crying [her/himself]" and "[the person] had a shouting and screaming episode - otherwise was fine". The recording of care did not demonstrate that people had been supported appropriately when upset or distressed.

These interactions and records indicated that people were not treated with dignity and respect at all times when they were receiving care and support.

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

Notwithstanding the above, one healthcare professional told us that they thought the staff provided emotional support and a high standard of care.

Staff closed bedroom and bathroom doors when providing personal care and helped people to be covered appropriately when they were moving between bedrooms and bathrooms.

Requires Improvement

Is the service responsive?

Our findings

The way in which care was provided was not always person centred and did not reflect nationally recognised good practice guidance. The provider did not ensure that people regularly participated in meaningful activities which offered stimulation or met their individual interests while they were at home. These issues meant that the service did not support people to have a good and meaningful everyday life and that people were not receiving care that was personalised for them to meet their assessed needs and preferences.

Staff did not respond to people appropriately when they used non-verbal ways to try to communicate with staff. For example, during our inspection visits we observed occasions when staff did not respond to people who were communicating in a non-verbal way. There were also instances when staff responded with comments such as "what's up?' and "what's going on?", they did not make eye contact and then walked away from a person without giving the person an opportunity to respond to them. We saw a number of instances where the staff responded by telling people to stop making a noise and moving them to another room to stop them making noises. The staff did not speak with people when doing this. There was no evidence the staff recognised noises and gestures people made as meaningful communication and they did not respond or find ways to maintain the communication.

There was information in people's care plans about how each person communicated their preferences and choices. However, there was no planned approach for how staff should communicate positively with people. For example, there were no communication plans for directing staff to use appropriate touch, objects of reference or other non-verbal methods of communication to interact with people. There were no documented approaches on how to give clear directions and prompting to people who may need these in a respectful manner or on how to respond positively to people who were known to frequently express their anxiety about things that were important to them.

Representatives of people who use the service and healthcare professionals told us that they had concerns about the level of engagement of staff and activities experienced by people while living at the home. Comments about the engagement and activities included, "there is room for improvement", "I didn't feel staff were motivating them to do anything" and "quite poor". One commented, "It could be the right place for [the person] if other things were in place, like people really looking out for [the person] … I think that [the person] could get a little bit more attention." Local healthcare professionals had discussed these concerns with the registered manager and team leader in July 2018.

The registered manager told us that it was important for people to receive intensive interaction with staff throughout the day and that staff time was specifically scheduled for this. For example, the manager said that "engaging with [the person] is the main thing, to give [the person] that one-to-one time" was particularly important for a person living with dementia who needed direct engagement or they would fall asleep during the day without this and not sleep well at night. However, during the inspection visits we observed this person sleeping with no interaction from staff throughout the day. None of the people experienced interactive one-to-one time with staff.

Staff interactions were mostly related to a care task (such as helping a person to eat or manoeuvre their wheelchair) or going out of the house. The daily care logs for two people indicated that over the course of the month prior to the inspection one person received allocated one-to-one time with staff twice and the other person received one-to-one time with staff three times. The logs indicated that these people spent most days in the lounge with the television on.
During both of our inspection visits Christmas music played on the television throughout the day and people using the service were not supported to choose or change this. People were left in the lounge or dining room with no other activity. One person was supported to leave the house both days and another person visited the doctor on the first day of our visit. There were no other organised activities for people on these two days.

People's sensory needs were not being met. At one point during the first day of the inspection, a person started pulling at the table cloth on the dining room table. The staff noticed and stopped the person. They moved the person away from the table but did not give them anything else to hold or do. The same person made noises and moved around in their wheelchair whilst listening to music on the second day of the inspection. A staff member moved the person away from the music and sat them in the dining room facing the empty table. They did not give them anything to do. The staff member showed no recognition that the touching of the table cloth, movement or noises made by the person were an indication of a sensory need or communication. Another person was taken to the sensory room once on each day. They were left in the room with some sensory lights but were not given any other support with sensory needs, such as touch, company, smells or music.

The provider did not ensure that people were included in the local community as much as they could, in line with CQC and national guidance on caring for people with a learning disability. People's access of the local community was limited to a small number of organised activities each week. For example, each person visited a local resource centre for a one and a half hour session each week. People's care plans identified the need for a range of activities for people and that each person had a personalised weekly activity timetable. However, these were not tailored to individuals as it was the same timetable for each person and it was not possible for the number of staff on shift to support each person with each activity at the same time, such as 'out in the community', 'shopping' or 'baking' sessions. Furthermore, the logs of care provided during November and December 2018 indicated that people did not take part in these planned activities. This meant that people did not consistently receive person centred care that helped them to experience positive and meaningful everyday lives when at home.

People had care and risk management plans in place that set out what their care needs were and how these should be met and prescribed a daily routine for each person. The plans included information about individuals' personal histories, their likes and dislikes and preferences. For example, what food they were known to like. The service completed moving and positioning assessments to determine how to safely support people with physical and mobility needs. However, staff told us that it was not always clear how to support a person safely when they required varying levels of support to move using mobility equipment. This was not set out in the person's care plan. The registered manager and team leader agreed that more detail needed to be added to the planned moving and positioning arrangements for a flexible approach to support the person safely.

The above issues meant that registered person did not ensure that people always received care and treatment which was appropriate, met their needs or reflected their preferences.

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

The registered manager had arranged for some activities for the people at home to be provided by visiting agencies. These were a fortnightly bible storytelling, a fortnightly music entertainer, fortnightly aromatherapy and monthly massage therapy sessions for some people. People had recently been supported to attend a Christmas party event arranged by the provider.

People's care plans indicated that end of life care needs had been considered and people had been supported to develop funeral plans. A person who used the service passed away several months prior to our inspection. The registered manager explained how the service had worked with the hospital and palliative care teams to support the person, who lived with profound learning and sensory disabilities, to return home from hospital so that they could receive care in their familiar home environment in their final weeks. Healthcare professionals we spoke with also told us that they supported this approach and that it would have helped the person to experience a more comfortable death.

There had not been any formal recorded complaints at the service over the last 12 months. There was a complaints procedure in place which was visible to visitors of the service at the entrance of the home. There was also an easy read version of this. However, the procedure advised complainants to refer their complaint on to the CQC if they were not happy with the provider's resolution, rather than to the local authority and the Local Government Ombudsman.

We recommend that the provider review their complaints procedure in line with current published guidance on raising complaints about adult social care services.

Inadequate

Is the service well-led?

Our findings

During the inspection we have identified multiple areas where improvements were required to help protect people from the risk of receiving care and treatment which was not appropriate and did not meet their needs. The provider's systems for identifying and mitigating risks were not always operated effectively. For example, there was insufficient guidance and training to ensure people were not at risk of choking and staff practices in this respect were not always safe. Additionally, cleaning products were not stored safely and medicines were not always managed in a safe way.

The service's systems for monitoring the quality and safety of the service were not operated effectively because the quality audit systems had not effectively assessed the quality of care, activities and staff interactions that people were experiencing at home. Nor had these identified that people were not always being treated safely and with dignity and respect. The auditing and review of the care records had not enabled the provider to identify where the quality and safety of care was not good so that they could respond to this appropriately.

On 1 October 2018 management staff borrowed £300 from one person using the service when the service ran out of petty cash and money was needed to buy shopping. The person did not have the mental capacity to consent to this. The provider only reimbursed the person two weeks later. This indicated that the management arrangements were not effective in ensuring that the service always had the necessary resources to operate without infringing on the rights of the people who lived there.

The provider had not submitted a Provider Information Return (PIR) to the CQC within the agreed timescales as required under section 64 of the Health and Social Care Act 2008. The provider did not demonstrate that it had an effective management process for ensuring that it can submit such information as required.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC awards a rating for the performance of registered services. The law requires providers to display this rating conspicuously and legibly at each location delivering a regulated service and on their website, if they have one. The registered manager had displayed the most recent performance rating at the home. We found that the provider's website did not display a CQC rating for this location and re-directed readers to an old CQC inspection report of the service from July 2014. We discussed this with the management staff and the provider started to update their website shortly after the inspection.

After the inspection, the provider's operations manager told us the provider had started to develop an action plan to address some of the issues that we had found during the inspection visits.

The registered manager has been in post since the last inspection and people's representatives and other professionals spoke positively about them. One healthcare professional said that the service had been "more settled now" since the manager's appointment. Another said of the home, "they provide a marvellous

service and have good staff and leadership". The registered manager had been on extended leave since beginning of October 2018 and had returned to work the week before the inspection. In their absence, the senior support worker managed the home. They told us that they found this a challenging and constructive learning experience. The senior worker was promoted to team leader in November 2018.

Staff told us that they had opportunities to speak with managers. Team meetings took place regularly throughout the year and these included discussions about practice issues and the people living at the service.

The registered manager and operations manager conducted periodic quality audits of the service. These included auditing medicines administration records, health and safety checks, the general cleanliness of the home, reviewing care logs, checks of the money held on behalf of people, and confirming fire and other safety systems were in order. These identified some issues for improvement that were then addressed, such as care plans requiring review, issues with the use of medicines administration records, and the holding of significant amounts of money on behalf of people.

There was an annual business and improvement plan for the service that had identified building or premises works that were required which were being acted upon.

People's representatives and other professionals were invited to complete annual stakeholder surveys to provide feedback on the quality of the service. This was last completed in December 2017 and the provider received positive comments about the service. The registered manager told us the surveys were due to be sent out again later in the month of the inspection.

The staff team had supported people who use the service to complete a feedback survey earlier in the year. The recorded responses noted that people wanted the flooring replaced and more activities.

The provider had continued to report notifiable occurrences to the CQC as required.

The service was working in partnership with external agencies and stakeholders and the registered manager had worked to develop this practice. Community professionals confirmed that the service contacted them regarding people's welfare and shared information with them appropriately. One described this joint-working as "a positive working relationship" and another told us, "Staff are friendly and give information when requested." One healthcare professional told us that it was the registered manager who leads on contacting other agencies and that the staff team could be supported to be more confident to raise issues themselves with other professionals when the registered manager was not there.

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 The registered person did not ensure that service users received care and treatment which was appropriate, met their needs or reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users because they did not always: -Assess the risks to the health and safety of service users receiving care. -Do all that was reasonably practicable to mitigate such risks. -Ensure the safe and proper management of medicines. Regulation 12(1) and (2)(a), (b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure that service users were protected from abuse and improper treatment because care and treatment sometimes included acts intended to

control or restrain service users and deprived them of their liberty without proper best interests processes or authorisations being in place.

Regulation 13(1), (4)(b) and (5)

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 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 31 March 2019.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity Regulation 17(1) The provider did not have an effective management process for ensuring that it submitted information to the CQC as required. Regulation 17(1)(3)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 31 March 2019.