Sheval Limited

Heatherside House Care Centre

Inspection report

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Date of inspection visit:
13 January 2020
17 January 2020

Date of publication:
22 June 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The service provides care and support for up to 25 younger and older adults with a diagnosis of learning disability and/or autism. Some people also have sensory impairments and/or physical disabilities.

Heatherside House Care Centre is in a secluded location which is geographically isolated. The service was a large home, bigger than most domestic style properties. It is registered for the support of up to 25 people. There were 18 people living at the service at the time of the inspection. Other people also used the service for respite care. This is larger than current best practice guidance.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons: People did not live in a service where a culture of enablement, independence, choice and inclusion enabled them to maximise their human rights and empowered them to be valued stakeholders in the service they lived in. People did not experience person centred care which was tailored to their individual needs.
People's experience of using this service:
Information to support people with their behaviour or mood was not always available, comprising enough detail or followed by staff.

Information recorded by staff was not routinely used to learn lessons and improve the support people received and the outcomes they experienced.

Recruitment checks had been completed on new staff members. New staff had completed an induction however, staff's induction records had not been completed fully.

People's needs had not all been assessed. Support was not always delivered in line with best practice.

People enjoyed the food but were not routinely involved in shopping for food. People's preferences for meals were sought each week but often people made no choice. The reasons for this were not reviewed to improve people's ability to contribute. People were not always provided with communication tools to help express their views.

The registered manager had not ensured the service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Conditions on people's DoLS authorisations had not been met. Staff were recording people's consent more frequently, but people had not consented to some aspects of their care.

No assessment of the environment had been completed to identify adaptations that would enable the service to better meet people's needs or align the service more closely with the principles of registering the right support.

Staff were mostly up to date with their training but had not received training in areas relevant to the people they supported, such as learning disability or autism.

People's health needs were supported by staff and people received their medicines as prescribed. People were not enabled to have as much control as possible over their medicines.

People were not always treated or described in a dignified way by staff.
People were not always involved in creating or reviewing their care plans. People's care plans did not describe how people could be empowered to develop skills in the home or community or increase their independence. Staff were not routinely encouraging people to do this following an agreed plan of action.

There were not always enough staff available for people to receive person centred care. People spent most of their time in the service and there was a lack of opportunities that had been tailored to people's individual interests and preferences, for people to engage with. Records showed people spent a lot of time in their room, sleeping, wandering or watching TV. Staff did not routinely support people to broaden their experiences to make informed choices about how they spent their time. People still did not have access to education or work opportunities, or support to develop skills within the service or community. The registered manager did not review how people spent their time, to ensure improvements and development opportunities were identified and acted upon.

The registered manager had not understood the principles of person-centred support or ensured they were embedded within the delivery of the service. The culture in the service did not reflect an aspiration to maximise people's human rights.

Learning available from previous inspection reports, the local authority quality improvement team and a consultant engaged by the service, had not all been implemented to improve the service.

The provider and registered manager had increased their monitoring of the service, but this had not resulted in sustained improvements to the outcomes people experienced. Audits of records had not identified areas for improvement found during the inspection. Records were not routinely reviewed to identify areas for improvement. We found many of the concerns raised at previous inspections still remained.

The registered manager had not engaged with any organisations, guidance or development opportunity that focused on best practice within learning disability services, to increase their knowledge and the outcomes people experienced.

We made recommendations about medicines, risk assessments and the complaints procedure.

Enforcement:
We have identified breaches in relation to how people with behaviour that challenges were supported, how information was used to aid learning, staffing levels and staff development. We also identified breaches in relation to how people's views were sought, understood and met, how people's needs were met under the Mental Capacity Act 2005 (MCA) and the governance arrangements of the provider.

Rating at last inspection: Inadequate 23 May 2019

At a comprehensive inspection in March 2017, we found ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included breaches of Regulation 12 (Safe care and treatment), 17 (Good governance), 18 (Staffing) and 19 (Fit and proper persons employed). We asked the

provider to complete an action plan to show what they would do and by when, to make improvements. We also served a warning notice on the provider and on the registered manager which required improvements to be made, so that the service met the requirements of Regulation 17 within six months.

In December 2017, we undertook a focussed inspection to check whether the service had addressed the concerns in the warning notices. At this inspection we only looked at the Well-led domain. We found that the requirements of the warning notice had not been met and there was still a breach of Regulation 17. Following the focussed inspection, we met with the provider to discuss how they were going to meet the requirements of the warning notice and improve the service to ensure that they were good in all domains.

At our inspection in November 2018, we found the quality assurance and governance arrangements for the home were still not sufficient to ensure people received safe, effective care. We found breaches of regulation 11 (Consent), 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing). Following this inspection, the provider submitted an action plan stating how they would make the required improvements. The service was placed in 'special measures'.

At our last inspection (May 2019) we found the provider had not made enough improvements. They had not ensured people were safe and felt safe. Consent had not always been sought from people about their care. The provider had not ensured all people's needs were assessed or met or that people were involved in decisions about their care or how it was provided. The provider had not ensured people felt comfortable with the staff supporting them. They had not made reasonable adjustments to enable people's needs to be met. People had not been empowered to make choices and have as much control as possible. The lack of choice and control over their daily lives meant people were not living lives as any ordinary citizen would. The provider had not ensured people's information needs were identified, recorded or met in line with national guidance. The lack of robust quality assurance meant people were still at risk of receiving poor quality care. We found continued breaches of regulations 11 (Consent), 12 (safe care and treatment), 17 (Good governance) and a breach of regulation 9 (Person Centred Care). Following this inspection, the service stayed in special measures and we took action to remove the location from the provider's registration.

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.

Following this inspection, the service will remain in special measures.

Please see the action we have taken at the end of the report.

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

The full details can be found on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Heatherside House Care Centre

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two adult social care inspectors and an assistant inspector.

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

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

Notice of inspection: This inspection was unannounced.

What we did: The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority quality team. We used this information to plan our inspection.

During the inspection:
We spoke with six people who used the service and one relative about their experience of the care provided.

We spoke with eleven members of staff including the provider, registered manager, senior care workers, care workers, activities co-ordinator and a member of the domestic staff. Some people could not easily communicate their views of the service, so we observed how people interacted with staff and how people spent their time.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at the provider's staffing tool and sought clarity on one person's care needs. We also contacted four professionals who knew the service well and spoke with six relatives by phone.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had not acted to ensure people's safety. There was a lack of guidance for staff on how to help people to manage their anxiety and incident records lacked details about what had caused people's anxiety. Risks in relation to unsupervised external contractors had not been appropriately managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12.

● People were not supported effectively to reduce behaviours that challenged themselves or others. Records showed people continued to have verbal and attempted physical altercations with each other and staff. We reviewed incident records from December 2019 to the date of the inspection and found seven records of people being described as aggressive or having an altercation. We were not confident that this represented all such incidents as some were recorded in people's daily notes rather than on the correct forms.
●Records for people who needed support to manage their behaviour or mood did not always include all relevant information such as potential triggers, clear steps to follow or when to use different techniques. Staff tried various techniques to help people manage their moods before offering as required (PRN) medicines to reduce anxiety, however not all of these were detailed in people's records and not all staff could describe them.
● Planned strategies created in conjunction with external professionals, were not used effectively to provide the emotional support people required. One person's care plan stated, "I can feel overwhelmed at Christmas and birthday but will usually enjoy them in the end". Records showed the person had told staff they wanted to die on 9 December 2019. Staff had attributed this to a change in the person's medicines and the build up to Christmas. A detailed strategy for staff to support them gave clear guidance regarding specific things staff should talk to the person about when they were unable to focus on the positives. Staff recorded that they had given the person time and then administered diazepam to help their mood. This did not reflect the strategy in place which meant they had not received the support tailored to their needs, as advised by a healthcare professional.
●Information was now recorded for each person detailing what made a good day and a bad day for them. However, four out of the six records we looked at had no detail to guide staff how to support people to avoid having a bad day. The other two records detailed only one sentence in each. These were, "I don't wish to be told 'no'" and "Shouting over the dinner table." It was not clear that these records added value to staff's understanding of how to support people.

● 'Ensuring Quality Services', produced by the Local Government Association and NHS England in response to the review of Winterbourne View, states that behaviour that challenges is reduced by better meeting needs and increasing quality of life. It says an important element of this is to develop the person's ability to influence what is happening, usually by supporting the development of communication techniques. There was no awareness or understanding of these principles in the service. Understanding and developing people's communication skills and their ability to make choices were not seen as routes to resolving behaviour that challenges.
●The registered manager told us people would raise concerns about their safety if they had any; however, people were only routinely asked if they had concerns at resident's meeting, which not everyone attended. One person told us they would not raise concerns unless asked and another person told us they did not feel safe but was unable to tell us why.

Systems were not in place to ensure staff had sufficient information and guidance to support people's behaviour and safety. This placed people at risk of harm. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● During our inspection we observed a senior manager laughing and mimicking the actions of one person in front of others in the service. We shared this information with the local safeguarding authority.
This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff were up to date with their safeguarding training and knew who to contact externally should they feel that their concerns had not been dealt with appropriately. For example, the local authority or the police. Safeguarding information was displayed for staff in their office.
●One of the building contractors now had a DBS check in place. They were responsible for supervising the other builders.
● Relatives told us they felt their family members were safe living at the service.

Learning lessons when things go wrong

At our last inspection the provider had failed to ensure learning was implemented following incidents relating to people's behaviour as details of possible triggers had not been recorded. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

● Information was not collected or reviewed in a way that aided learning. Staff did not maintain consistent records in relation to people's anxiety and events that challenged staff or others. Some incidents were recorded using ABC forms which included details of what was happening before, during and after someone used behaviour that challenged others. However, these records were not completed for all these types of incidents. Some incidents related to people's behaviour were recorded on incident forms and some were recorded in people's daily notes. This failure meant the service did not have an accurate understanding of the number of types of incidents that had occurred.
● The registered manager told us "We will do trend analysis if there have been any trends but there have not been any, so we have not done that." It was not possible for the service to identify patterns and trends in people's behaviours as incidents had not been appropriately documented. This failure exposed people to a potential risk of harm.

● Outcomes of support provided to people was not recorded effectively, to aid learning about the person's support needs. A healthcare professional had devised a strategy for staff to support one person's mental health. The strategy stated, "Staff are to ensure I have the time each day to discuss how I feel my day has gone with the negatives and positives. Staff to document the outcomes." Staff told us the person often declined this support, but records had not been completed of occasions when the person declined to participate and why. The person confirmed they often declined because they didn't feel up to it. The failure to consistently record these outcomes, meant it was not possible to identify further learning about how they needed their support providing.

The service's failure to appropriately record incidents meant it was not possible to identify patterns and trends in people's behaviour. This unnecessarily exposed people to a potential risk of harm and was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we made a recommendation about recruitment procedures and staffing levels. At this inspection we found recruitment procedures had improved but found staffing levels still had a negative impact on people's choices and opportunities.

● The options and choices available to people were, at times dictated by staffing levels. The level of support people could receive from staff after 7pm was limited as there were only two staff members available for 18 people. One person wanted to regularly use an armchair they had purchased, however there was a risk they could slip or fall out. A risk assessment stated they had agreed only to use it in communal areas and not between 7pm and 7am as there were only two staff on duty then. This meant their freedom and choices were limited by staffing levels.
● The number of staff available each day to support people had increased since the last inspection. The registered manager told us they aimed to have 4 or 5 care staff working each day. The rota showed on average, there were five staff members available to support 18 people from 7am until 7pm. There was also an activities co-ordinator available four days a week. However, this meant, on average, each person would be able to receive less than 4 hours support each for all their needs, between 7am and 7pm. Due to the needs of the people living in the service and its remote location, these staffing levels were not sufficient to meet people's needs and provide the levels of support needed for people to be as independent as possible and experience free choice.
● Staff told us they thought there were enough staff on duty to meet people's needs. However, the provider's dependency tool to calculate staffing levels showed 9 people had been allocated 60 minutes or less staff contact time, over 24 hours. Two people were allocated no staffing time for "Communication/ prompting, social and emotional" support. There was no-one living in the service who did not need any support in these areas.
● People did not have free choice to go out when they wanted to due to staffing levels. The registered manager told us it would not be practical to have more staff members on the rota. They told us, "It would be great to have 10 staff on the rota, so everyone is out when you come to inspect but it's just not practical." They explained that if people chose to stay at home in the day rather than go out, there would not be enough work for ten staff members to do. They had not understood providing person-centred care within the service based on enablement, independence, choice and inclusion also required higher staffing levels. A healthcare professional told us they believed that if the service had more staff this would increase the opportunities for interaction and engagement.

The provider had not ensured sufficient staff were available to provide a person-centred service for people.

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

● Before new employees started work at the service pre-employment checks were carried out including DBS checks. Following the last inspection, the registered manager had ensured new staff recorded their full career history on their application forms.

Using medicines safely
● Most people were not provided with the opportunity to take control of their own medicines. One person took responsibility, with staff support to administer some of their medicines. Other people's care plans stated they should be encouraged to take a more active role in the management of their medicines. There was no further detail recorded about what support each person would require to achieve this and it had not happened for other people. Nobody told us they wanted to have more control over their medicines, however staff did not routinely encourage people to develop skills towards taking a more active role with them. This was not promoting a culture of enablement or independence.
● Prescribed creams were not always recorded correctly. Information was not always available about what people's prescribed creams were for, where they needed administering or, for 'as required' creams, how staff would identify they needed administering. This information was particularly important as some people could not easily communicate their needs. For example, a staff member described an action one person used to indicate they wanted a pain relief cream applying. This information was not in their care plan, which meant staff who did not know this person, may not recognise what they were indicating and therefore not be able to provide appropriate support.
● Staff did not consistently complete the medicines administration records (MAR) for people's creams. Sometimes they noted on a different record they had administered people's creams. This meant it was difficult to have oversight of whether people had had their creams administered as prescribed or not. The registered manager told us they were aware of this concern.
● Other medicines were mostly recorded accurately when administered. However, we found some gaps in people's MAR which had not been identified by the provider's auditing processes.

This formed part of the breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had their medicines reviewed regularly with their GP and/ or psychiatrist.
● People told us they were happy with the way staff administered their medicines. Staff had received medicines training and assessments of their competence to administer medicines.

Assessing risk, safety monitoring and management
At our last inspection we made a recommendation about reviewing the means by which people could call staff if they needed help. At this inspection we found people's needs in this area had now been assessed.

● People had risk assessments in place.
● Regular checks had been completed of the environment, equipment and facilities to ensure they remained safe for people.
● Personal evacuation plans had been put in place to guide staff and emergency services what support people would need in an emergency.

Preventing and controlling infection
● Staff had received infection control and food hygiene training.

- The provider had completed an infection control audit.
- People told us they were happy with the cleanliness of the home.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

At our last inspection the provider had failed to ensure information about people's social and emotional needs had been sought or guidance provided for staff about how to meet them. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

● People's care was not being delivered in line with evidence-based guidance. There were several people who exhibited behaviour that challenged others. The department of health's Transforming Care (produced following the review of Winterbourne View), states people with behavioural needs benefit from personalised care, not large congregate settings. However, this information had not been used to assess the environment in order to improve people's quality of life and promote their wellbeing.
● The principles of positive behaviour support, such as considering how physical and social environments could better meet people's needs, helping people develop skills to enhance the opportunities for them to have independent, interesting and meaningful lives and considering people's whole lives and understanding how that impacted on their behaviour, had not been used. This meant their quality of life was not enhanced and the likelihood that the behaviour would happen again was not reduced.
People's care was not being delivered in line with evidence-based guidance. This contributed to a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service was not providing care in line with registering the right support. People were not provided with opportunities to manage as much of their care and treatment as they were able to. Some people's care plans stated that their aim was to take more control, or more of an active role in certain aspects of their support. People had not always been consulted about these aims. There were no steps or guidance for staff to follow detailing how they could support the person to achieve these aims. Staff and the registered manager confirmed people were not consistently supported to achieve these aims. This resulted in people not being fully supported or encouraged to work towards independence or have more autonomy in decisions about their life.
● The full range of people's needs and preferences had not been considered when assessing the support they required. For example, people's needs in relation to maintaining or developing every day skills such as

cooking, doing laundry, managing money, maintaining their home or shopping for food had not been assessed. Very few people were supported to develop or maintain skills in these areas. This meant people did not have full opportunity to live lives as ordinary as any citizen.

The provider had not ensured people were supported to have autonomy or involvement in the community. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to ensure people were enabled to take control of planning meals or buying food. They had not ensured people's support needs in relation to eating and drinking were met in a dignified way. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

● People were not all enabled to contribute to the service's menu. People were asked what they would like to eat each week and any suggestions were incorporated into the menu. We looked at records of people's food choices across six weeks. Eight people had not made any choice over the six weeks we looked at. There was no system in place to review the records or identify why these people had contributed. The registered manager confirmed no communication aids were used to help people make requests for the menu each week. This may have affected people's ability to make suggestions. This was not promoting a culture of enablement, independence, choice and inclusion as detailed in registering the right support.
● People were still not routinely involved in buying food for the meals planned. No assessments or care plans were in place detailing people's needs or preferences in this area.

The provider had not ensured people's care was designed to maximise choice, inclusion, control and independence. This contributed to the continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they enjoyed the food and had enough to eat. People who needed support to eat were provided with the support they needed and treated with respect.
● People's dietary needs were recorded in their care plans and staff were knowledgeable about these. When people needed the amount they ate and drank monitored, staff consistently recorded this information.

Adapting service, design, decoration to meet people's needs

At our last inspection we made a recommendation about seeking people's views regarding how the environment could be used to meet their individual needs. At this inspection we found this issue had not been resolved.

● Heatherside House was registered to provide accommodation for up to 25 people which is more than the maximum of six people recommended in Registering the Right Support. At the time of the inspection, 18 people were living in the service.
● The provider had not adapted the premises or changed practices since the last inspection to reflect the principles behind registering the right support. This impacted on people's quality of life and their wellbeing.

The registered manager told us they had discussed some ideas about how the physical environment could better meet the principles of Registering the Right Support but explained no action plan or business plan had been created as they did not know whether the service would still be open following the inspection.
● The design of the home and the way it was used still had not taken into consideration the mix of people's behaviours, needs and preferences. The registered manager had discussed the environment with people in a resident's meeting. However, no assessment had been undertaken to identify ways it could be tailored people's needs and reflect best practice guidance. Therefore, no clear alternatives to the current layout had been shared with people to ensure they had sufficient information to make an informed choice. One person's records showed they were regularly distressed by other people making noise outside their room. However, there had been no consideration made of how the environment could be better used to help reduce the levels of anxiety for this person or others.
● A small kitchen area was still available for people to use. However, adaptive equipment such as a kettle that would enable people to pour boiling water more safely, to help develop skills and promote independence was not available, and it was not designed to meet the needs of one person, who used a wheelchair.

The provider had not ensured the environment was tailored to meet people's needs and preferences. This formed part of the continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was planning to develop the garden, so people could be involved in growing plants and vegetables.
● People's bedrooms were personalised with their possessions. One relative told us their family member was particularly happy with their bedroom.
● A healthcare professional told us they felt the service was a warm and friendly home to people who live there.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure they had complied with Mental Capacity Act 2005 (MCA), or that consent was always sought before care or support was provided to people. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 11

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● People's capacity had not always been assessed in relation to restrictions imposed on them. Two people were not able to eat solid food safely as they were at risk of choking. Staff told us one of these people did want to eat solid food. Staff did not allow them to eat solid food but no assessment of their capacity to understand the risk had been completed. This meant their rights may have been breached.
● Best interests' decisions had not always been made following best practice. Some people did not have family involvement with managing their finances and did not have the capacity to do this themselves. Best interests' decisions had been made on their behalf for the provider to manage their finances. However, the provider was recorded as involved in the best interests' decision with no external professional involved. This was a conflict of interests.
The provider had not ensured the service was working within the principles of the MCA. This was a continued breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● The service was not complying with the conditions of people's DoLS authorisations. Two people had had DoLS authorised. The conditions for one person stated staff had to provide meaningful occupation such as encouraging them with life skills and domestic tasks, ensure regular activities in the week, work with the person to produce a weekly timetable of activities and clearly record if they took part in these during the week. None of these conditions had been met and there was no detail in the person's records detailing what staff needed to do, or what support the person needed to ensure these conditions were met.
● A condition for the second person stated the DoLS team had to be informed of any further restrictions. The person now had a pressure mat in place for some of the day which was a further restriction on their free movement. No mental capacity assessment, best interests' decision or update to the DoLS application had been completed which meant their rights may not have been upheld.
● Staff recorded on a daily basis when people had consented to or refused support with the main aspects of their care. However, staff checked on most people throughout the night even though their consent had not been sought. The registered manager had been advised in September 2019 that people's consent needed to be sought and recorded, but this had not been completed yet. Two people had their shaving equipment kept in the staff office. There was no information to show why, or that they had consented to this.
We shared this information with the relevant managing authority.

The provider had not ensured that conditions on authorisations to deprive people of their liberty were being met or that consent was sought for care provided. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Assessments of people's capacity in relation to certain aspects of their care were in place. Staff knew which people had DoLS applications submitted on their behalf.
● A healthcare professional told us they had never witnessed a staff member doing an activity with a person without gaining consent first.

Staff support: induction, training, skills and experience

At our last inspection we made a recommended the provider reviewed processes to ensure all staff had completed training specified as mandatory by the provider.

● At this inspection we found staff were mostly up to date with the training the provider had allocated as mandatory and there were plans in place to provide training for staff who weren't up to date. However, the provider had not identified training covering best practice in supporting people with a learning disability or related needs, as necessary. The registered manager told us staff had not received training in learning

disabilities or provision of meaningful activities since working at the service. They told us staff had not completed autism training for a long time. The activities co-ordinator had still not received any training about providing meaningful pastimes and opportunities for people with a learning disability. This meant staff did not recognise poor practice within the service.

● Following the last inspection, the registered manager highlighted Registering the Right Support in a staff meeting and told staff they needed to be aware of it. No further training or development opportunities were made available for staff to understand how to do this. Staff told us they felt people were receiving a good service but had not been supported to understand how to meet best practice in a learning disability service.

● We looked at the induction records of three new staff members who had been employed since May. These had not been fully completed, so it was not clear that they had been inducted according to the provider's policy. A further staff member confirmed they had completed an induction but there was no record to confirm this. The registered manager told us they weren't sure how this had happened, but the staff member would not have worked with people before shadowing staff.

The provider had not ensured staff had the correct skills, knowledge and competence to deliver best practice within the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us new staff were only able to support people when people were comfortable with them. A staff member confirmed this.

● The registered manager told us staff would be completing care planning training and that staff had received training on breakaway techniques. They explained this training also included information about how to de-escalate challenging situations.

● Staff told us they could ask for any training they wanted, worked well as a team and felt well supported by the registered manager.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Staff understood people's healthcare needs and had received the correct training to help people manage any risks.

● People regularly saw healthcare professionals to help ensure their health needs were being met. Advice was sought and followed regarding people's health needs.

● When people had specific healthcare needs, clear guidance or protocols from healthcare professionals were included in people's records.

● People had oral health care plans in place which described what support they required to maintain their oral health. A relative told us their family member received good oral care.

● A healthcare professional told us they were impressed with staff's knowledge of people.

Requires Improvement

Is the service caring?

Our findings

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

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At the last inspection this key question was rated as 'requires improvement'. At this inspection this key question remained the same.

Respecting and promoting people's privacy, dignity and independence
At our last inspection we made a recommendation about how people's privacy, dignity and independence were promoted. At this inspection we found not enough action had been taken in response to this recommendation.

● People were not always treated in a dignified way. One person sometimes chose not to respond to staff. Their communication care plan told staff "I can sometimes choose not to acknowledge you or choose not to answer. This is just who I am." A member of staff confirmed the person could hear but sometimes chose not to respond. On the first day of the inspection the person was choosing not to respond to staff, but two staff members shouted to ask if the person wanted a cup of tea, as though they had a hearing loss. Staff did not respect this person's dignity and commented, "I don't know what's wrong with her today."
● A human rights approach had not been used to ensure better outcomes and the right to enjoy the highest possible quality of life were at the heart of the service development. The culture of the service was not based on fairness, respect, equality, dignity and autonomy. People's needs were not always considered and catered for in a way that gave them equal access to the service and the community. A new mini bus was being used that people who used wheelchairs could use. However, we found no further tangible examples of how the provider's approach to equality and diversity at Heatherside House translated into quality outcomes and equality of opportunity for people who used the service.
● People were not encouraged to do as much as possible for themselves. People's care plans directed staff to help people develop their independence but provided no further detail about the support they required from staff in order to do this. No aims or goals were set, to help people achieve greater independence. Staff still completed the majority of household tasks in the service. A staff member asked one person, "Where do you want your dinner? Go and sit down then and I'll bring it to you." The person was not supported or encouraged to collect their own dinner. The registered manager told us two people sometimes helped in the kitchen but people were not routinely encouraged to be a part of meal preparation. A staff meeting was used to remind staff to empower people to be independent, however systems, processes, staffing levels, and staff's lack of understanding of good practices in learning disability care, within the service did not support staff to do this.
● Words staff used to describe people's behaviour were not always respectful. For example, one person was regularly described in their notes as, "roaring". A record of an incident of challenging behaviour had a confrontational tone, stating, "Told […] if he fell he could spend Christmas in hospital. He then backed off."

It did not record that the person was treated with respect or offered reassurance or empathy. A staff member described someone's behaviour to an inspector as, "having a meltdown".
● People's confidential information was not always protected. Following the inspection, the registered manager shared with four relatives, a written feedback summary provided by the inspector to support the verbal feedback about the inspection. The feedback included information about individuals and their records. The information contained on the summary, had caused one relative some concern.

People were still not always treated with dignity and respect and their independence was not supported. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff knocked on people's doors before entering.
● A staff member told us they were proud they had been able to support a person who does not like going outside, to go out for lunch. They told us it was a work in progress and about building trust.
● A relative told us staff had a warm relationship with their family member and always had a cuddle for the person.
● A healthcare professional told us they had seen some people become more independent since living in the service.

Ensuring people are well treated and supported; respecting equality and diversity
At our last inspection the provider had failed to ensure people had positive relationships with the staff who supported them. They had not ensured reasonable adjustments were made to enable people's needs to be met. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

● Minutes of a residents' meeting showed one person had told staff they found it difficult when people talked about certain family members as theirs were no longer alive. The minutes of the meeting stated, "[Staff] did explain that residents who have family are going to talk about them as it is important to them." There were no records to demonstrate what action or additional support had been offered to this person in response to the concern they had raised.
● People's preferences and wishes were not always valued by staff; for example, one person required specialist footwear but often declined to wear them. They had recently wanted to buy a new pair of shoes reflecting their individual taste. Staff had told them they would not be able to find ones to fit them, they had not supported the person find a suitable alternative or solution.

The provider had not ensured people's care was designed to meet all their needs and preferences. This was part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed some caring interactions between people and staff. One staff member told us, "I like looking after them and caring for them and going out with them." A relative told us how a staff member had supported their family member to write their name in a Christmas card they had sent. Another relative commented, "From what I've seen, they do as much as they possibly can to keep […] happy."
● A healthcare professional told us all staff were kind, friendly and supportive to people, they had never seen staff be disrespectful or use inappropriate behaviour or language and felt people came first.

Supporting people to express their views and be involved in making decisions about their care
At our last inspection the provider had failed to ensure people were enabled to communicate using their preferred method. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

● People were not always enabled to express their views. Records showed on many occasions people did not express their views about how they wanted to spend their time or what they wanted to eat. No plans had not been developed to help staff better understand people's communication needs or their views.
● Information was contained in people's care plans about their communication needs. However, these records did not include detail such as the meanings of specific signs or gestures people used. Some people used Makaton signs to communicate. Most staff had not completed Makaton training.
● Low staffing levels meant there was not enough time available for staff to support people to make meaningful decisions and choices about how their care was provided. During the inspection staff were often observed redirecting people into another room, or offering them a cup of tea, rather than spending time identifying what the person's preference would be.

The provider had failed to ensure people were provided with the correct tools and support to communicate effectively. This forms part of a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A person whose communication tool was not available at the last inspection, now had this available.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

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

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people were empowered to make choices and have as much control as possible over their lives. The lack of choice and control over their daily lives meant people were not living lives as ordinary as any citizen. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● People did not have as much choice and control as possible over their lives. People had not been supported to experience a range of opportunities that enabled them to make informed choices. This reduced the number of options people were aware of, which limited their choices and their ability to live full lives. For example, people who regularly chose not to go out were not routinely encouraged or motivated to find opportunities they would find engaging and meaningful.
● People did not have true choice or control over the way they were supported. The registered manager told us some people were encouraged to be involved in creating their care plans, but others were not. People's care records were reviewed regularly but this did not always involve the person. Reviews were not used to consult people on their views of the service. For example, one person told us they would need staff to seek their views of the service before sharing them. There was no system in place to ensure this was done.
● People had not all been involved in creating the documents about themselves. 'This is me' information was recorded for people and included an overview of how they liked to spend their time. Information was also recorded about what made people happy and what was important to them. A care plan entitled 'activities' recorded how people liked to spend their time. The information in these documents was not reflective of people who lived an ordinary a life as any citizen. There was minimal information recorded in some of these documents and this was often repeated across all the documents. For example, one person's 'what makes a good day record stated, "Moving around. Looking around. Coke." Another person's recorded, "Helping out with tasks. Playing games in the lounge."

People's needs and preferences were not always met in a way that maximised the choice and control they had over their life. This forms part of a continued breach of regulation 9 (Person Centred Care) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's care plans described their preferred routines for certain aspects of their support.
● People who wanted to, had been supported to vote in a recent election.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure people were supported to follow their interests or to develop relationships within the wider community to reduce social isolation. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● People still did not receive sufficient support to follow their interests or develop further knowledge and experience of activities they might enjoy. People's care plans stated their aims were, "To implement a programme of activities that will motivate and inspire me." Programmes of activities had not been created for individuals. People were asked regularly how they would like to spend their time and what their hopes and dreams were. However even though some people could not easily communicate verbally, no communication aids were used to help people make choices.
● People's choices usually reflected the things they had always been offered as they were not routinely encouraged to try new things or broaden their experiences. One person's care plan stated, "Staff need to continue to find ways of expanding my experiences by asking me what I would like to do. Staff to try and get […] to engage in new activities and identify new things […] would like to try." This person's records had no pastime or interest recorded for 16 days in November 2019. The activities they had requested included a haircut, a coffee morning and buying a newspaper. They had mostly achieved these things but there was no evidence that the person's care plan to expand their experiences, had been followed.
● Staff told us people were offered group activities and asked what they would like to do each day. However, most people's records showed they had not been supported to engage with meaningful activities regularly. For example, four people were recorded as watching TV, in their room or had nothing recorded, for more than half of November 2019. Of the nine people whose records we looked at, most people took part in the planned group activities three or less times in November 2019.
● Requests and choices people made were not always met. One person had requested in August 2019 to go out in the car and get coffee, get a new watch, a trip to a local town, go out for dinner with staff and go to Plymouth. The record of what they had achieved only stated, "Using my hand ball to exercise my bad hand. Practice my speech." In September 2019 they requested a walk round a local town, the cinema and a garden centre. None of these were recorded as achieved but no reasons were recorded. They went to the cinema in November 2019. On 25 November 2019, they had requested to go Christmas shopping, out for dinner and to a local town. The record of what they had achieved only stated, "Enjoyed Christmas. Liked my new watch." People had been asked during resident's meetings in July and September for ideas of things they would like to do. The registered manager confirmed many of the ideas, some of them as simple as a fish and chip night, had not yet happened.
● Information about how people spent their time or what they regularly declined, was not used to identify other opportunities they might find meaningful. People's care plans stated, "Staff to monitor, document and evaluate the outcomes of activities enabling a comprehensive programme of suitable activities to be devised." Staff told us they had to respect people's choices, if they declined activities. However, the information was not used to help the person plan alternatives they might find more engaging, or to improve

their future opportunities. Staff recorded at the end of the month what people had achieved. When people had not achieved the goals they had chosen, reasons had not been consistently recorded or reviewed.

● During the inspection we observed people were not regularly engaged in meaningful pastimes. Most people were in the service most of the time, wandering, watching TV or in their room. Many people's activities care plans recorded their aims were, "To have a full and varied programme of activities that I have been instrumental in devising" People's records and our observations showed individuals did not have a full and varied programme of activities. A relative told us about their family member, "[…] likes to join in and loves being near people. They like to have life around them." However, they told us they thought the person spent most of their time in their room. Records showed the person spent 22 days in November 2019 in their room and only joined in planned, group activities in the home on four occasions. The relative described how the person had enjoyed being active and still enjoyed exercise when they went out together. They told us, "I'm sure […] would like to go out more." Records showed they only went out four times in November 2019.

● Staff did not use engagement to support people to reduce behaviour that challenged. One person's care plan stated, "Staff to support and promote activities that will stimulate and divert my attention from less destructive behaviours. To minimise episodes of detrimental behaviour with more constructive outlets." The hopes and dreams recorded each month for this person were to go for a drive each day, walking round the garden and play with their soft toy. The person did enjoy going for a drive, but these hopes and dreams were the same for August, September, October and November 2019 even though the person had not wanted to go for a drive every day. There were no records to show that staff had attempted to support the person to find more stimulating activities.

● Opportunities for meaningful engagement with people were missed by staff and reduced the positive outcomes people experienced. During the inspection one person spent most of their time wandering round the service and we observed them using a toy to gain staff and the inspector's attention. This action had not been understood by staff as a request for meaningful engagement, so staff instead threw the toy back and usually supported them to go to a different room or to have a cup of tea. Records of how the person spent their time often described the person as following staff round the home. This again did not result in meaningful interaction with the person. Instead, 'playing catch' with the soft toy had been incorporated, into the person's records describing their interests, their hopes and dreams, what made a good day and what was important to them.

The provider had not ensured people's care was designed to achieve their preferences and meet their needs. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People were not provided with sufficient support to avoid social isolation. Staff and most relatives thought people went out often enough. Some people living in the service were older and their relatives told us they did not always want to go out regularly. However, we looked at the records of how nine people spent their time in November 2019. Five of the nine people whose records we looked at, went out less than six times in 30 days. The service was in a remote location which meant people needed support to use the local community or visit the nearest villages and towns. This placed people at risk of social isolation. Staffing levels in the service meant people usually went out in groups which meant activities were not tailored to individual's preferences. If people went out individually, their time would be limited as other's would also need the staff member's support.

● People still did not have access to education or work opportunities or support to develop skills within the service or community. The registered manager confirmed no-one had been offered the opportunity to work, volunteer, attend educational opportunities or develop the skills required to do these since our last inspection. One person's social worker had asked the service to provide three hours per week of one to one staff support to enable the person to gain skills around the service or engage in the community. There was

no record this had happened and no plan of how the person wanted to be supported to spend their time. No staff had been allocated on the rota to provide this support.
● We observed people, who were able, did not routinely receive support to develop and maintain every day skills such as cooking, doing laundry, managing money or shopping for food. Some people were involved in household tasks such as laying tables, laundry or sweeping, but there were no assessments or care plans specifically describing people's needs, aims, or what support they required to develop skills in these areas of their life. Following the previous inspection, the registered manager had used a resident's meeting to ask people if they were happy with the procedures in place for cleaning their rooms and discussed how people's finances were handled. Minutes of this meeting stated, "They know if they would like to take ownership, we will support them"; and that if anyone wanted to change the way their finances were handled, "We would support them with alternatives." No individual discussions or assessments were completed. Staff were reminded at a staff meeting that a small kitchen in the service always needed to be accessible to people. We were told two people regularly used the kitchen to make drinks, but the registered manager had not monitored whether staff were encouraging others, and it had not happened for most people.

The provider had not ensured service users were supported to develop or maintain autonomy, independence or involvement in the community. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us they had enough to do with their time.
● Staff supported some people to visit family members or attend family occasions.

Meeting people's communication needs
At our last inspection the provider had failed to ensure people's information needs were identified, recorded or met in line with national guidance. This was a breach of Regulation 9 (Person Centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The requirements of the AIS had not been met. People's communication care plans did not describe how they required information presented so they could understand it. The registered manager had not ensured information produced in the service for people was produced in a format that met their needs. Information from people's care plans was not available in an accessible format to enable people to participate meaningfully in reviews of their care.
● Not everyone chose to attend residents' meetings. The registered manager told us residents' meeting minutes were typed up and made available to people. However, most people at the service were unable to read. No easy read versions were developed to support people's understanding or enable people who had not attended the residents meeting to participate in the decisions made.
● Communication tools were not routinely used with people who might benefit from them. This meant people's views and decisions were not all understood. Often people did not communicate any preference when asked about the support they wanted.
● People were asked at a resident's meeting following the last inspection whether they would like food

menus to be available in pictures. Several people said they would like this. These were used to show people what the options were each day, but they were not used to help people share their preferences when the menu was being planned. Several people regularly did not contribute a preference.

The provider did not have appropriate systems in place to enable and support people to make decision in relation to how their care was provided. This failure forms part of the continued breach of Regulation 9 (Person Centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's records contained some healthcare information in an easy read format to help people understand what about specific health conditions staff supported them with.

Improving care quality in response to complaints or concerns

● The service had a policy and procedure in place for dealing with complaints. It was available in an easy read version, but this was kept in the staff office. People did not have a copy. The registered manager told us if people had concerns they would raise them at resident's meetings. However, they also told us not every person attended resident's meetings. They told us they ensured they gathered views from people who didn't attend but had no records of these.
● A relative told us when they had raised concerns about the previous inspection outcome, they had only been told their family member was being well looked after, but nothing more. They told us they had not felt reassured.
● Most people told us they would feel confident making a complaint.

End of life care and support
● People's end of life wishes were discussed with them and, where possible, documented as part of their care plan.
● Staff had received training on providing end of life care.

Inadequate

Is the service well-led?

Our findings

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

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

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to ensure people were fully engaged in the development of the service or ensure people's human rights were protected. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17

● People had a service provided to them but were not engaged or valued as part of the service. People were not fully involved in the design and development of the service. People were not always provided with the correct communication tools or support to communicate their ideas about the service or their care. People and their relatives were still not included in the recruitment of new staff.
● Learning was not used to enhance people's ability to be involved in the design of their own service. When people regularly shared no preference or consistently shared the same preference, no review was completed of how they were being supported to make choices, or how increasing their experiences could empower them to make informed decisions. This meant people were not meaningful partners in developing a service tailored to meet their wishes.
● Since the last inspection, one sentence had been added to the provider's equality and diversity policy which stated the service would support people to have an equal and valued place in society. There was no detail about how this would be achieved. The provider had not understood that in order to provide a good service, understanding equality and meeting people's human rights needed to be an integral part of the service delivery.
● Relatives told us they were contacted if there was a problem but not all relatives felt they received regular information about their family member. One relative told us, "I have no idea what [...]'s life is like there." They added that if they wanted information about their loved one, they had to contact the service.

The provider had not ensured people were engaged and involved in the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt engaged with the service. One staff member told us, "You can talk to the manager, they understand, and they are approachable."
● A survey had been used to collect feedback from people's family and friends. The results were all positive.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

At our last inspection the provider had failed to maintain an effective overview of the home or taken sufficient action to make the required improvements identified in the previous inspection. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had again failed to achieve compliance with the requirements of the regulations and remained in breach of regulation 17.

● Concerns about the provider's governance framework had been identified at three inspections since March 2017. These related to the failings of the provider's governance framework which left people in receipt of poor quality care. Improvements were still required at this inspection. The provider and registered manager had still not ensured they had an effective overview of the service, that concerns were identified and improvements that reflected best practice were made. A new governance policy had been put in place which stated the service and provider were committed to, "Complying with key legislation and social care policy, adopting adult social care values, good business practice and ensuring regulatory compliance." However, there was no further detail about how this would be achieved. The policy stated the director and registered manager of the service would always, "Adopt best practice and constantly improve the service." However, the registered manager confirmed they and the provider had not engaged with organisations or research to identify what current best practice was.
● Audits and checks were not being used effectively. A programme of audits was in place however, there was no clear audit of risk assessments. This had resulted in some people's risks having no related assessment.
● Completed audits had not always identified gaps in records. We identified that one staff member had not completed an induction when they started work and others had gaps in their induction records which had not been identified. Other gaps we found in people's records, such as missing care plans for 'daily living skills', missing information in people's communication care plans and lack of clarity about why people's requests had not always been met, had also not been identified.
● The provider had still not ensured the service met the values and principles that underpin Registering the Right Support. The service was secluded and geographically isolated which created barriers to people's involvement in the local community. These barriers had not been considered or reduced in the design of the service. The service design, including staff levels, meant delivering person-centred care was not achievable.
● Enablement, independence, choice and inclusion were not embedded in the culture of the service. The provider and registered manager had failed to understand and comply with the requirements of the Mental Capacity Act 2005. People were not supported by staff who had an understanding of positive behaviour support. These elements all impacted in people's lives and meant they were still not living as ordinary a life as any citizen.

The provider had not effectively monitored that quality of the service or ensured it met with regulatory requirements. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At our last inspection the provider had failed to ensure information was used to inform learning and improvements to the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17

● Information available to the service had not always been used to improve the quality of support people received. The registered manager told us they had relied on the information from the local authority about how to improve the service. They had also engaged a consultancy firm. However, during the inspection elements of the action plans provided by these organisations remained incomplete.
● The local authority quality assurance team had added mealtime observations to the service's improvement plan to be completed monthly. Their report showed at a visit in October 2019, this was marked as completed but the registered manager had only completed one and could not find it. This was also the case at the quality assurance team visit in November 2019. At the time of the inspection, still only one mealtime observation had been completed. The consultancy firm had identified that improvements could be made in relation to best interests records, people's involvement in care plans and a daily walkaround. However, we found these areas had not been addressed prior to this inspection.
● Concerns identified and feedback provided following previous inspections had not all been acted upon. Although some improvements had been made. The breaches identified during the previous inspection still remained.
● The registered manager told us since the last inspection they had contacted a local community and voluntary service to review their activities programme; however, the organisation was not focused on best practice in learning disability services. The registered manager told us they had not engaged with any further organisations or guidance to increase their knowledge of best practice within learning disability services. This meant their ability to ensure the service and staff followed best practice was limited. For example, the provider told us they were not aware of STOMP. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project started in 2016 which helps to stop the over use of these medicines.
● The registered manager told us they had attended performance management training and supporting workers mental health. However, these were not directly related to improving the outcomes of the people living in the service.
● Records were not consistently maintained or regularly reviewed. This meant the service was unable to identify trends and patterns in people behaviour or learn from incidents that had occurred. There was no clear strategy about how to improve each person's care and the service overall.

The provider's oversight and governance arrangements continued to fail to use information to effect change and improvements in the service. This was part of a continued breach of continued Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
At our last inspection the provider had failed to ensure people received a person-centred service which was inclusive, empowering and supported them to achieve good outcomes. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of

regulation 17

● The registered manager had not understood the principles of person-centred support or ensured they were embedded within the delivery of the service. They told us they thought people living in the service had the same opportunities and choices as any other citizen. However, people were unable to leave the service when they chose because of its remote location and the current staffing arrangements.

● The culture in the service did not enable people to have maximum control and choice. Staff regularly told us if people refused to take part or share preferences, that was their choice. However, people were not encouraged to progress or develop their skills, interests or abilities. Goals were short term and concerned with known interests rather than personal development. The provider and registered manager had not ensured people were provided with sufficient information and experiences to make informed decisions. People were not consulted about their preferences in a meaningful way, using appropriate communication tools and where people had identified goals they had not always been supported to achieve these aims.

●The registered manager was in the home most days so was aware of how people were spending their time. However, they did not have a system to review how people were spending their time and how often people were engaged in pastimes that were meaningful to them. This meant no learning was taking place to enable staff to tailor the service to people's preferences or enable them to develop further interests and pastimes. For example, one person liked to walk to the local shop regularly. Records noted how happy they were that the shopkeepers dog greeted them. However, there was no process is place for staff to identify and learn from this information to improve the person's outcomes. When we highlighted this to staff, they suggested the person might like to try volunteering at a local dog sanctuary but told us people's information was not used in this way to identify opportunities.

● The provider and registered manager had understood people needed to be supported to develop further daily living skills. However, they had not ensured people were encouraged, motivated and empowered to take more control over the tasks in their life and in their home. They had not provided staff with relevant training or increased staffing levels to enable people to be supported and encouraged to complete more tasks independently.

● Information displayed in the service suggested people had regularly been supported to develop certain skills, when this was not the case. For example, one notice stated, "Staff have been working with service users to promote independence. Individuals have been choosing what meals they would like to cook as an activity. They have been writing a shopping list. Then supported by staff go to the shop and get their shopping. They then write a method, cook the food and then have it for tea." A staff member told us this had only happened twice and only with one person.

The provider's oversight and governance continued to fail to ensure people received a person-centred service which was inclusive, empowering and supported them to achieve good outcomes. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A staff member told us, "I love it here. I like the way it is their home and it is very homely."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

● The registered manager was honest about information we sought during the inspection.

● A healthcare professional told us they found the staff and management to be open and honest.

Working in partnership with others

●The registered manager had engaged with the local authority quality team with a view to improving the service. However, at the time of the inspection not all these improvements had been made.
● A professional told us the service communicated well with them about people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not being delivered in line with evidence-based guidance. The provider had not ensured people's care was designed and delivered to maximise choice, inclusion, control and independence. The provider did not have appropriate systems in place to enable and support people to make decision in relation to how their care was provided. They had failed to ensure people were provided with the correct tools and support to communicate effectively. They had not ensured the environment was tailored to meet people's needs and preferences.

The enforcement action we took:

Remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were still not always treated with dignity and respect and their independence was not supported. The provider had not ensured service users were supported to develop or maintain autonomy, independence or involvement in the community.

The enforcement action we took:

Remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the service was working within the principles of the MCA.

The enforcement action we took:

Remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure staff had sufficient information and guidance to support people's behaviour and safety. The service's failure to appropriately record incidents meant it was not possible to identify patterns and trends in people's behaviour. Medicines practices did not always follow best practice.

The enforcement action we took:

Remove location

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 provider had not ensured people were protected from degrading treatment. The provider had not ensured that conditions on authorisations to deprive people of their liberty were being met or that consent was sought for care provided.

The enforcement action we took:

Remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured people were engaged and involved in the service. The provider's oversight and governance continued to fail to ensure people received a person-centred service which was inclusive, empowering and supported them to achieve good outcomes. The provider had not effectively monitored that quality of the service or ensured it met with regulatory requirements.

The enforcement action we took:

Remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient staff were available to provide a person-centred service for

people. The provider had not ensured staff had the correct skills, knowledge and competence to deliver best practice within the service.

The enforcement action we took:

Remove location