Care and Normalisation Limited

Milestone House

Inspection report

188 London Road
Deal
Kent
CT14 9PW

Tel: 01304381201
Website: www.milestone-house.com

Date of inspection visit:
21 November 2019

Date of publication:
17 January 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Milestone House is a residential care home for people living with learning disabilities and/or autism and physical disabilities. The care home accommodates 11 people in one adapted building.

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. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

Milestone house was a large service, bigger than most domestic style properties and was clearly identified as a care service. It was registered for the support of up to 13 people and 11 people were using the service. This is larger than current best practice guidance.

People's experience of using this service and what we found
People continued to be at risk of harm. The provider continued to fail to report allegations of abuse in line with the law. The provider had failed to take appropriate action following a whistle blowing. People's risk assessments were not reflective of the care provided and new staff could not tell us how they kept people safe. Accidents were not managed effectively and to ensure lessons were learnt.

People were at risk of serious harm if there was a fire. The fire risk assessment was not robust, checks were not always completed, and staff did know the evacuation procedures. We have alerted the fire and rescue service of our concerns. They have visited the home and asked the provider to take some urgent actions.

People were at risk of being cared for by unsuitable staff as not all the required safe employment checks were completed. There were not always enough staff available to meet people's needs. We have made a recommendation about this. Medicines were not managed safely as people did not always receive them as prescribed. The provider had employed a cleaner since the last inspection. The service was clean, and people were protected from the risk of infection.

The provider had not ensured care was always delivered in line with good practice and the law. People's care plans did not include the guidance staff needed to support people in line with their needs. Staff were not given the training, supervision and support needed to ensure they were competent to support people effectively. New staff had not received an adequate induction to their role and did not have all knowledge required about people's needs.

People were not always supported to eat and drink enough and monitoring records for this continued to not be fully completed. People were enabled to eat independently where possible.

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 and in their best interests; the policies and systems in the service were not followed to support this practice. We have made a recommendation about this.

The service did not apply the full range of the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons, lack of choice and control and limited inclusion, for example people could not choose to go out when they wanted to.

The provider had not always ensured people were well treated. The provider had not sought people's views and involved them in their care. We have made a recommendation about this. People's confidential information was not always kept private. People's dignity was promoted. Staff were caring and there were positive interactions with people.

People did not receive person centred care. People's care had not been regularly reviewed and updated in their care plans to reflect their changing needs. People did not have a good quality of life as there were not enough staff to support people to go out when they wanted to. People were not given as much choice as possible and enabled to have meaningful activities to do. Some staff knew how to communicate with people, but people's communication needs were not always met. There had not been any complaints, but people were not enabled to raise concerns.

The provider had not ensured they had good oversight of the safety and quality of the care. Systems were not used to identify improvements needed. Incidents were not analysed for further learning and feedback was not sought as a means of learning and improvement. The provider has not addressed the improvements needed since they received their last inspection report. There was a track record of staff leaving following raising concerns about the service. The provider had not promoted a person-centred service and the culture of the service was not open and positive.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 20 November 2019).

Why we inspected
The inspection was prompted due to concerns received about the service and the registered manager who was also the provider. A decision was made for us to inspect and examine those risks.

The concerns about the service included unsafe moving and handling transfers of people, unsafe medicines management; and a punitive approach to supporting people with behaviour that challenged. The concerns about the provider was about a failure to respond to and report incidents raised by whistle blowers; a failure to work within their own policies and a failure to promote person centred care.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
There is current enforcement action being taken from the previous inspection in September 2019. Therefore, where the breaches of regulations remained at this inspection we have not taken any further enforcement action. The timescale for the completion of actions to improve had not been reached and we will review at our next inspection.

We have identified two new breaches of regulation at this inspection. There was a failure to ensure people were protected from the risks associated with the employment of unsuitable staff. The provider did not ensure people were supported to have enough to eat.

Please see the action we have told the provider to take at the end of this report.

Follow up
We have met with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Milestone House

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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

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. The registered provider was also the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 sought feedback from a local authority who commission the service and a health and social care professional who works with the service. We used all this information to plan our inspection.

During the inspection
People living at Milestone House were not able to fully share with us their experiences of living at the service. Therefore, we spent time observing staff with people in communal areas during the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager at the beginning of the inspection on the phone. They had another commitment on the day of the inspection and was not able to be there. We spoke with six members of staff including a team leader, assistant team leaders and support workers. We spoke with a visiting health and social care professional who works with the service.

We reviewed a range of records. This included five 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 rotas, training data, and incident records were reviewed.

After the inspection
We received feedback from two professionals who regularly visit the service.

Inadequate

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 now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● People were at risk of being supported by staff who were not suitable. Staff were not always recruited safely as not all the required pre-employment checks were completed by the provider. For two new staff there were unexplained gaps in their employment histories. One staff only had one referee and there was no Disclosure and Barring Service (DBS) background checks evidenced for one staff. DBS checks help employers to make safer recruitment decisions. Since the inspection the provider has evidenced DBS checks were completed.

The provider had not ensured that staff were of good character as they had not completed all the safe recruitment checks required by law. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended the provider seeks advice from a reputable source on their employment strategies. The provider had not made improvements. We continue to recommend this and will follow this up with the provider.

● The provider had assessed the required staffing levels for people's dependency needs although there was no formal method for this. Staffing levels during the inspection day were appropriate to meet people's needs. However, there had not always been enough staff to meet people's needs.

● Agency staff continued to be used where possible to help with staffing levels and there was on-going recruitment. However, there had been some unfulfilled shifts. We were told this was because the agency was unable to supply staff, and no-one was available to do overtime. The biggest impact on people was they were not enabled to do meaningful activities or go out.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider did not effectively operate their systems to ensure people were protected from the risk of abuse. 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.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made and we found further evidence to support a continued breach of regulation.

● The provider had not ensured people were protected from the risk of abuse. Systems and policies were in place to protect people from abuse and avoidable harm. However, the provider had continued to not report all allegations of abuse to the local authority. This meant people were at risk of not being protected from further abuse if the local authority did not have oversight of what action had been taken.
● An incident of unsafe moving and handling of a person had been reported to the provider. This put the person at risk of physical harm from unsafe moving and handling practices. The provider failed to fully act on the concerns raised. Therefore, the whistle-blower informed the Care Quality Commission (CQC) who made a safeguarding alert for this.
● At the last inspection, staff told us senior staff would listen and act upon any concerns. However, before this inspection, two staff told us that the provider had failed to take appropriate action following a whistle blowing. There had not been a full investigation of the incident and not all appropriate actions had been taken. There were no written records available. Since the inspection the provider has evidenced that some disciplinary action was taken.
● Staff knew the types of abuse and how to report these. Staff training in safeguarding people was not always completed or up to date. The provider's policy was for an annual refresher and some staff had not had an update in over five years.

Assessing risk, safety monitoring and management

At our last inspection the provider did not have robust systems in place to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made and we found further evidence to support a continued breach of regulation.

● People were at risk of receiving inappropriate care or a failure in care. Individual risks to people were not always identified, assessed and managed safely. Risk assessments were not always kept up to date or did not always reflect the care provided. Not all staff knew how to keep people safe. For example, new staff did not know when to call for emergency medical help if one person with epilepsy had a seizure. New staff did not know what to do if the fire alarm sounded and had not completed a practice evacuation. There was a failure to manage the risks to one person who was not always eating.
● The risk assessment for one person's mobility needs had not been kept up to date. It did not reflect the person's support plan and guidance from health professionals. The person was fully reliant on hoisting for transfers, but their risk assessment read they used a stand aid. A stand aid is specialist equipment that can help a person stand up. New staff told us the hoist was not always used to transfer the person from the toilet to their bed. Staff were not clear what they should be doing. This put both staff and the person at risk of injury from unsafe moving and handling practices.
● People were at risk of serious harm if there was a fire. There were significant gaps in the testing of the fire alarm system and emergency lights. The emergency lighting had only been checked once in July 2019. Staff were not clear how often the fire alarm system should be checked. Fire training had not been completed and kept up to date by all staff. Fire drills had not been held regularly. Staff gave incorrect and contradictory accounts of the actions they would take in the event of a fire. The fire risk assessment had been reviewed since the last inspection. However, the review had not been robust and had failed to identify these shortfalls.

● People had personalised emergency evacuation plans to provide guidance to staff on the support they needed. However, risks to people had not been assessed correctly. People who were high risk because they

needed support from two staff had been assessed as being at low risk. Correct information about the risks to people was not available to staff and the emergency services. Laminated grab cards were available near the fire panel to ensure people's needs were known in the event of a fire. However, these were not in place for three people.

We have alerted the fire and rescue service of our concerns. They have visited the home and asked the provider to take some urgent actions.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made. and we found further evidence to support a continued breach of regulation

● Medicines were not always managed safely as people did not always receive their medicines as prescribed. Medicine records were now checked daily to ensure people had received their medicines. However, the provider had still not ensured all medicines were given as prescribed as there was not always the guidance needed for staff. This put people at risk of harm.
● There had been at least 25 missed doses of pain relief medicine for one person since it was prescribed on 23 September 2019. Staff were unclear whether this medicine should be given twice a day when they transferred from and to bed. Or if it was to be given 'as required' when the person said they had pain. One staff told us this medicine was not always given even when the person complained of pain. The deputy manager identified it was given 'as required' in error when it should have been given twice daily. The deputy manager had written a message to inform staff of the correct administration. However, there were no formal guidelines for staff and this continued to be given incorrectly.
● One medicine for two people was required to be taken 30-60 minutes before food to be an effective digestive aid. There was no evidence that this was managed. Medicines records had set times which staff signed against rather than the exact time given. Staff told us that people were sometimes given these during or after food. This medicine should be given with water to enable it to be swallowed whole. Staff told us some staff gave this to people without water and they would chew it. The medicine needed to be swallowed whole to enable it to pass through the stomach and dissolve in the intestine. It should not be chewed as it can irritate the mouth, throat and stomach.
● Staff administering medicines had not had their competency in doing so checked as per the provider's policy. There were appropriate systems in place to store and dispose of medicines safely. Regular checks were done that medicines were stored at the right temperatures and creams were dated on opening.

Preventing and controlling infection

At our last inspection the provider did not ensure the prevention of infections was effectively managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. Some improvements had been made.

● An environmental health officer had visited the service since our last inspection and have asked the provider to take some actions. Fridges were now maintained at safe temperatures and there was guidance available for staff on this.
● Staff had received training in food hygiene and infection control. However, some staff, including senior staff were more than two years overdue for an update on these. Staff could tell us what they did to prevent and control infection, such as wearing gloves and not coming to work if they are unwell.
● Information about how to prevent the spread of infection was present and personal protective equipment was available and used by staff. There was handwashing equipment and information in the kitchen and around the service.
● The provider had employed a cleaner since the last inspection and the service was clean.

Learning lessons when things go wrong
● Accidents and incidents were not managed effectively. Since the last inspection two accidents had occurred resulting in people needing hospital treatment. In both cases the accident record was incomplete. The accidents were not reviewed, and the records did not describe in detail the action needed to reduce the risk of reoccurrence.
● One person had fallen because of a seizure. The post incident, management only informed staff how long they take to recover typically and that the person is aware what happened. There was no evidence of review of the persons care plan or risk assessment. For another person who had fallen some staff had not been told about the responsive actions to be taken. For example, there was no formal system to complete observations on return from hospital. Therefore, staff did not know how often they needed to observe the person.
● The provider had not analysed incidents and accidents for any trends to identify any learning. For example, there had been no analysis around falls, the number of falls, times and locations to see if anything could be learnt from this.

Inadequate

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 now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At our last inspection we recommended the provider consider current guidance on monitoring peoples nutrition and hydration needs. The provider had not made improvements.

- People's needs around eating were not kept up to date. For example, one person had not eaten anything on at least five different days in a 19-day period. No action had been taken to address this and daily records only recorded the person had declined to eat. There was no reference to this in the persons care plan. For example, there was no guidelines for staff how to encourage the person to eat and what to do if they don't eat. The person had only been weighed once in July 2019. Therefore, there was no monitoring if the person had lost weight or identifying of this risk.
- The same person did not always want to eat in the dining room as they found it too noisy. Therefore, staff supported them to eat in a staff area near the kitchen. They did not appear to be given a choice to eat in their bedroom. The persons care plan did not have any of this information yet in speaking with staff it was clear this often happened. We asked a senior staff member about this and was told that they used to eat in their bedroom a few years ago. This was stopped as there was concerns they were isolating themselves in their room.
- Monitoring of people's dietary intake, fluids and weight where people were at risk of dehydration, malnutrition and weight loss was still inconsistent. People's fluid charts were still not totalled against a target amount to ensure enough fluid was taken. There was information and guidance in the kitchen around food allergies and people's dietary needs. New staff were aware of people's needs in relation to risks associated with eating and drinking. For example, where people needed soft diets due to the risk of choking. However, they did not know what to do in the event someone had a choking incident.
- There were positive interactions between staff and people during lunchtime. However, people could not always choose where they ate and who with, whether in the dining room, lounge or in their bedroom. Lunch was held in the dining room in two sittings due to the size of the room and the support people needed. People were given adapted plates and cutlery to enable them to eat independently.

The provider had not ensured that people were supported to eat enough. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the care and treatment of people was appropriate and met their needs. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made and we found further evidence to support a continued breach of regulation.

● Care was not always delivered in line with good practice and the law. For example, people were not always supported safely when transferring to a chair or their bed. Staff had transferred one person by manually lifting them. This was unsafe practice and against the guidance provided by healthcare professionals and the persons support plan.
● People continued to not receive person centred care that was appropriate and inclusive for them and which focused on opportunities. People's outcomes did not reflect the promotion of choice, control and independence in line with the principles of registering the right support. People did not always achieve the best quality of life. For instance, staff deployment had continued to significantly impact on the amount of activity people could do within and outside of the service. There were not always enough staff or drivers available to enable people to go out if they wanted to.
● People with behaviour that challenged were not supported in line with current best practice. There was a lack of staff knowledge as to the reasons why people may display behaviour that challenged and how to manage this positively. This was evidenced in records and the response to incidents. There was a lack of positive behaviour strategies with guidelines for staff. For one person the information was over 10 years old and not available in the person's daily records for staff to refer to. This meant staff did not have the information they needed to support the person. Staff told us a new behaviour therapist was working with this person to produce updated management plans.
● People's needs were fully assessed before they moved to the service. However, people's risk assessments and care plans were not kept up to date and did not include all the information needed. For example, around their eating and drinking and mobility. People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessments. This included for example, people's needs in relation to their culture, religion or disability. Staff completed training in equality and diversity, although most staff were overdue for their training update on this.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were suitably qualified, competent and skilled to meet people's needs. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made and we found further evidence to support a continued breach of regulation.

● Two new staff who had started since the last inspection were not given an adequate induction. Whilst they had worked alongside experienced staff for some shifts. They had not completed the necessary training and did not have the knowledge they needed on people's needs. For example, around how to support people with their epilepsy, the risk of choking and positive support of behaviour that challenged.
● Staff had not always received appropriate training and regular refresher training to support people living at the service and to meet individual's needs. For example, staff had not received appropriate training

around service users' individual needs in epilepsy. This meant the provider could not be assured that staff had the skills and qualifications to fulfil their role and meet people's needs.
● Staff had not received regular supervision, appraisals and competency checks in line with the providers policy. Staff were not effectively supported when they were involved in incidents with people with behaviour that challenged. For example, staff were not given the opportunity to debrief and reflect on incidents where they had been physically assaulted.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires 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.
● A best interest process had not been followed for people who could not give informed consent to the CCTV that covered all communal areas. Staff told us the CCTV live feed was often left running in the providers office. The CCTV was not used in line with the providers policy and invaded people's privacy.

We recommend the provider seeks guidance from a reputable source on implementing MCA and take action to update their practice accordingly.

● The provider worked with the local authority to seek authorisation where people were deprived of their liberty. Staff were aware of the principles of the MCA and guidance was provided to them within people's care records. Care records promoted people's rights and documented consent.
● Decision specific mental capacity assessments were completed, and a best interest process followed in relation to some decisions about people's care and treatment. For example, around the use of bedrails. Staff who knew people well could establish whether consent to care was given in their day to day choices, for example when providing personal care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always referred to appropriate health and social care professionals as required. For example, the person who sometimes did not eat for the entire day had not been referred to their GP or a dietician. People had been referred to occupational therapists. However, an occupational therapist had made recommendations around specialist equipment people needed but these had not all been purchased. Therefore, people were using equipment which didn't fully meet their needs.
● People's relatives and other health and social care professionals were involved in people's care. However, information was not always shared about people's care appropriately to support their best interests and promote positive outcomes for people. For example, a recent safeguarding incident for one person was not shared with their advocate when they visited shortly after the incident.
● People had 'healthcare passports' in place. These ensured other healthcare professionals were aware of

people's needs and how they communicate, for example in the event they were in hospital.
● Records were maintained for all health appointments, for example with people's GP, dentist and optician.

Adapting service, design, decoration to meet people's needs
● The environment was accessible and met people's basic needs. There were communal areas in the service where people could eat their meals, could watch television, listen to music or engage in activities. People could choose to spend time together or meet their visitors in communal spaces or spend time alone in their room.
● There was only one mobile hoist for staff to use. Staff told us they needed another as sometimes they had to wait for it to be available. This had resulted in staff moving a person manually as they were uncomfortable, and they didn't want to wait.
● The provider had adapted the environment to meet the needs of people where possible. For example, one persons en-suite bathroom layout had been adapted to enable them to access the toilet using their walking frame. People had their own specialist armchairs and wheelchairs. The second floor was accessible via a stair lift.
● Since the last inspection one person had been taken out to choose some pictures to make their room more personalised. People could be supported to go out into the community in the company vehicle and one person had their own vehicle.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

At our last inspection we recommended the provider seeks advice from a reputable source on involving people in their care. The provider had not made improvements. We continue to recommend this and will follow this up with the provider.

- There was no evidence that people were asked about their views on their care, for example through care plan reviews. Information was not gathered formally on people views of the service and their care, for example through surveys.
- People were supported to access advocacy services if needed. Advocacy services offer trained professionals who support, enable and empower people to speak up.
- There were pictures of staff on a board in the dining room so that people knew who was on duty.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had not always ensured people were well treated. For example, people that showed behaviour that challenged were not always supported in a positive way. One person who displayed behaviour that challenged when receiving personal care did so due to the pain they felt when moving. This resulted in them being left to calm down and told their behaviour was not acceptable. Consequently, the person would then sometimes decline to get up and they were left in their room for 24 hours and had nothing to eat.
- Support staff we observed were caring with people. We viewed positive interactions throughout the inspection. For example, people were given reassurance that their drink was not too hot to drink. One person was asked if they were ok as staff thought they looked more tired than usual.
- Some staff knew people well and could recognise how people were feeling. For example, they knew if people were happy or not by the sounds they made.
- The provider had considered people's needs around equality and diversity. No one had identified with a certain religion or showed any interest in their cultural background.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always respected as information about people was not always held securely. The provider had rectified concerns raised at the last inspection regarding people's care records not stored securely in the downstairs staff office. However, people's daily care records were held in the dining room in an unlocked cupboard and the door was left open.

● Staff promoted people's dignity. Staff told us how they upheld people's dignity when providing personal care. For example, knocking on bedroom doors before entering, asking people's permission before doing something, covering the person up and explaining what they are going to do.

● People were encouraged to maintain their independence where possible. For example, one person used a frame to enable them to walk independently. People used adapted cutlery and plates to enable them to eat their meal independently. However, one staff told us staff were prevented from encouraging and supporting people to complete daily tasks.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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 the care and treatment of people met their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made and we found further evidence to support a continued breach of regulation.

- People's care was not person centred. Whilst their care records included some information about promoting choice, who was important to them and where known their life history; care plans were not always up to date, accurate or put into practice. The local authority had previously informed the provider care plans needed to be more person centred. The provider had failed to act on this.
- People's care had not been regularly reviewed and updated in their care plans to reflect their changing needs. For example, one person had recommendations from a health professional in June 2019 to ensure their meals were served on a contrasting plate colour. This was to support their visual needs. This information was not in their care plan which had not been reviewed since March 2019.
- People were not always given as much choice as possible, for instance a choice in what they ate. There was one meal choice each day and people were not meaningfully informed what it was. Staff told us that people were asked if they wanted what was on the menu in the morning. If they didn't, they could choose something else. However, this did not ensure people had real choice due to their communication needs. For example, pictures were not used, and an alternative was not offered.
- On the day of the inspection people were having fish pie for lunch. We were told everyone had been asked if they wanted it and all agreed. Staff knew one person didn't like fish pie from when they had it previously. The person did not eat this. Staff asked them if they would like something else. The person agreed but did not say what, they were offered eggy bread as staff knew they liked this, and they agreed. Staff could have acted sooner to offer the person a wider choice of meals in a way that was appropriate for them.

Meeting people's communication needs
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.

● People's communication needs were not always met. People's care plans included details which helped unfamiliar staff learn how people expressed their needs, for example if they used pictorial aids. However, despite at least two new staff working on the day of the inspection, there was no evidence these were used. When asked for one person's pictorial aids, it took staff some time to find where they were.
● Senior staff had worked with speech and language therapists to ensure staff had the information to support people effectively with their communication needs. Information was available to some people in formats which met their communication needs, for example the use of pictures in care plans. There were some visual aids around the service, for example informing what staff were on duty. A noticeboard in the dining room for pictures of the daily menu was again not used on the day we inspected.
● The provider used a well-known assessment tool to help them understand distress in people with severe communication difficulties. However, these had not always been completed.

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
● Apart from a few people having a foot massage by a visiting therapist, there was a lack of meaningful activity on offer on the day of our inspection. People were either in their rooms or sitting in the lounge. The radio was on in the morning and the television in the afternoon. One person played cards with staff in the morning. Another person had their nails polished by staff in the afternoon. For most people their time was spent sitting passively unless they were given a drink.
● On the day of our inspection one person went out to meet their relative for lunch. Two staff took the person to the venue and collected them later. However, people could not choose to go out into the community when they wanted. Staff told us this had improved since the last inspection. One person had been swimming and two people had attended an activity session. People were not supported in line with the principles of registering the right support. People were not always enabled to take part in activities they liked, especially if this involved going out.
● People were supported to maintain relationships that were important to them. Friends or family could visit at any time.

Improving care quality in response to complaints or concerns
● A complaints procedure was in place for people, relatives and visitors. This was in an easy read pictorial form for people. Most people would need to be supported by their relative to make a complaint. Where people didn't have close relatives, they had an advocate to speak on their behalf.
There had not been any complaints. However, there was not an open culture which encouraged complaints as the provider had not sought people's views. The provider had not considered other methods to recognise if people were happy. For example, people withdrawing or having behaviour that challenged may have been as they were unhappy with their care.

End of life care and support
● The provider was not currently supporting people at the end of their life. People's wishes and arrangements for their end of life care were not always known. Therefore, staff did not have the guidance they would need to support people in line with their wishes should an unexpected death occur. This remains an area for improvement.

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.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had not operated effective systems and processes to assess, monitor and improve the safety and quality of the service and ensure it was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The timescale for the completion of actions to improve had not been reached at this inspection and we will review at our next inspection. However, improvements had not been made and we found further evidence to support a continued breach of regulation.

- The governance framework had not ensured the delivery of high quality and safe care. The provider had not ensured they had good oversight of the quality of the service. Quality assurance systems, such as audits, checks, observations and daily monitoring were still not used effectively to monitor all aspects of the service. Health and safety monitoring records were not always completed, for example around fire safety. There was no evidence at the inspection of any improvement plans following the last inspection.
- Following our previous inspection, the provider was required to complete an action plan by 4 December 2019. This was to tell us what improvements they would make to ensure allegations of abuse were reported. We have not received this action plan. Improvements needed had been identified by the local authority in March and April 2019. The provider had still not taken timely and appropriate action to ensure these were done. For example, they had not completed regular reviews of people's care to empower people and staff to ensure the process was more person-centred.
- There was no clear drive on improvement by the provider based on continuous learning. There was a lack of feedback sought to learn from. The provider did not actively seek feedback about the quality of the service. There was a lack of analysis of accidents and other activities or outcomes to identify areas for improvement from lessons learnt. There were no formal plans to improve people's care.
- Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider had continued to not meet all their regulatory requirements as they had failed to notify CQC of another allegation of abuse.
- It is a legal requirement that a provider's latest CQC inspection rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had not displayed a copy of their current ratings at the service.

However, these had only been received the day before the inspection. The law requires them to be displayed within 21 days of publication.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff were not supported when they raised concerns and issues raised were not always taken seriously. There was a track record of staff leaving after raising concerns about the service. At least two staff had left since the last inspection as they were not happy with how the provider managed concerns they had raised.

● The provider had not promoted a person centred and high-quality care service. The provider had not taken accountability for the improvements needed since the last inspection report. There was still a lack of recognition of the need to work within the principles of registering the right support. There was a lack of understanding of good practice when working with people living with a learning disability and/or autism; and in particular when supporting people with behaviour that challenged.

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 law requires providers to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The provider told us they understood their responsibilities in respect of this at the last inspection. However, there was no evidence they had been open with one person and their advocate following a recent incident. The advocate had visited the week after and was not informed of the incident.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were not fully engaged with the service. There were no systems in place to seek feedback from people and their relatives of their views on their care and the service. The provider had failed to promote this.

● The provider had not always worked well with other agencies. For example, occupational therapists from the local community learning disability team. This team had recently offered to run a meaningful engagement group at the home. The provider had not worked with them effectively to achieve this.

● For one person who had recently moved to the service, the provider had met with their care manager to review how they had settled in.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people were supported to eat enough. Regulation 14 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not completed all the safe recruitment checks required by law. Regulation 19 (2)(a) (3)(a)