R Cadman

The Old Rectory

Inspection report

45 Sandwich Road
Ash
Canterbury
Kent
CT3 2AF

Tel: 01304813128

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out on the 31 July 2018, 01 and 08 August 2018. The inspection was unannounced on 31 July and 08 August 2018 and announced on 01 August 2018.

The Old Rectory 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 Old Rectory provides care and support for up to 40 people who have physical disabilities, learning disabilities and autism. People's needs varied and some people needed lots of support with communication and their healthcare needs. Some people were living with autism and some people needed support with behaviours that challenged. On the day of our inspection there were 31 people living at the service.

The registered provider was in charge of the day to day running of the care home. A registered provider is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations, about how the service is run.

We carried out our last comprehensive inspection of this service on 31 January and 1 February 2018 and we gave the service an overall rating of 'Requires Improvement.' At that inspection we found six breaches of the legal requirements of the Health and Social Care Act Regulated Activities Regulations 2014. The breaches related to Regulation 9- person centred care, the registered provider had failed to ensure that people received person centred care. Regulation 12- safe care and treatment, the registered provider had failed to ensure that care was provided in a safe way to people. Regulation 13-safegaurding people from abuse and improper treatment, the registered provider had failed to ensure that restrictions on people's liberty was appropriately authorised. Regulation 17- good governance, the registered provider had failed to maintain accurate and complete records. Also, the registered provider had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. Regulation 18- staffing, the registered provider had failed to ensure that staff were fully trained to be able to complete their roles effectively. Regulation 19- fit and proper persons employed, the registered provider had failed to ensure that staff were recruited safely. We also found a breach of the Care Quality Commission (Registration) Regulations 2009, Regulation 18- notifications of other incidents. The registered provider had failed to notify CQC of notifiable events in a timely manner.

We also made three recommendations. The recommendations related to the management of cleanliness and infection control, the management of complaints, the management of end of life care planning.

After our last inspection the registered provider sent us an improvement action plan telling us how they intended to meet the legal requirements of the Health and Social Care Act Regulated Activities Regulations 2014 and the Health and Social Care Act Registration Regulations 2009. They told us they would meet the regulations by 01 May 2018. At this inspection we found there had been an improvement to Regulation 19- fit

and proper persons employed, but we found continuing breaches of Regulation 9- person centred care, Regulation 12- safe care and treatment, Regulation 13-safegaurding people from abuse and improper treatment, Regulation 17- good governance and Regulation 18- staffing. We also found breaches in Regulation 10-dignity and respect, Regulation 14-meeting nutritional needs and Regulation 15-premises and equipment.

We found one of the recommendations had been acted on, which was the management of end of life care planning. The management of complaints had been partially met. However, we found the other recommendation had not been implemented, which was the management of cleanliness and infection control.

At our last inspection we found that the care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. This best practice guidance is there to promote modern, inclusive, empowering care and support in services that include accommodation for people with learning disabilities and autism. At this inspection the service people continued to receive care which was not based on current best practice including Registering the Right Support.

We observed unsafe care. Staff had received training about protecting people from abuse. However, the registered provider, the deputy manager and the staff lacked a clear understanding of their responsibilities in preventing abuse. There had been an allegation that people had been exposed to inappropriate physical behaviour within the service and there were records of people's belongings being taken by others. The registered provider and staff were dismissive towards the allegations and failed to take proper steps to protect people whilst the allegations were investigated. The arrangements that were in place to safeguard people from the risk of abuse were not adequate as incidents had not been reported to the local authority and CQC.

People's safety was being compromised in a number of areas. The management of risks relating to people's health, safety and well-being were inadequate. This put people at risk of serious harm.

The provider did not have a system to assess the number of staff needed to meet people's safety and basic care needs at all times This led to people being at serious risk of neglect.

The registered provider was not deploying enough staff to meet peoples funded and assessed needs. This created an institutional environment in the service. People were left for long periods without staff care, people were unoccupied and observed people moving around the service without interaction with other people or staff. There was a lack of opportunity for people who needed staff to support them to participate in their local community, with some people not leaving the service for days or weeks.

People who displayed behaviours which were challenging and a risk to others had not been properly assessed and there was no plan to mitigate risks. People did not have proper risk assessments or care plans in place to ensure they were adequately supported. This put them, and other people in the service at risk of harm. The registered provider had not taken any action to ensure people were cared for and supported properly and to ensure people were not harmed. The registered provider had not promoted a learning culture when managing and responding incidents or accidents.

Care plans lacked information about people's health and care needs. They were not sufficient to enable staff to plan people's care, manage risk and respond to people's needs. When people's needs changed, for example if their behaviours became progressively worse, their care was not properly reviewed. Referrals

were made to outside community services, like the community nursing teams, but they were not followed up with any urgency.

The registered provider had not met their action plan to provide training for staff. They had not included the actions they intended to take in response to all of the breaches and recommendations we made at our last inspection on their action plan. Training about 'person centred care' and the management of challenging behaviours had not been received by the staff responsible for the delivery of care. People's needs had not been assessed in line with best practice when supporting people with learning disabilities. Staff had not received accredited training in positive behaviour support or de-escalation techniques, even though some people displayed behaviour that could be challenging. Other training specific to people's needs, such as autism had also not been provided.

We continued to find that there was a lack of accessible communication and tools in place to assist people with more profound needs to make their needs known. Adjustments had not been made for people with hearing or visual impairment so that they were involved. There was no systematic plan in place to increase people's independence, involvement in the service or to enable people to test, develop, and learn new skills. People were not enabled to gain new skills nor increase their independence.

Staff we observed during the inspection had a caring approach, but they lacked the skills and knowledge to recognise the culture in the service was institutional and uncaring. There were people in the service who had become isolated in their bedrooms or by the lack of person centred care, but staff failed to recognise this. There were not enough activities to keep people occupied in a meaningful way. People were not always involved in the planning and review of their care and care plans were not written in an accessible format to enable people to do so.

Although people had access to specialist nursing support from the learning disability community teams, the staff managing the service did not have the skills, qualifications or expertise to meet people's needs.

People's health and wellbeing were not protected by the proper assessment and management of their nutritional and hydration needs. Not all people were provided with appropriate opportunities to have food, snacks and drinks.

People had access to GPs but their health and wellbeing was not supported by prompt referrals and access to medical care if they became unwell. Good quality records were not kept to provide information to health care professionals and guidance was not provided to assist staff to monitor and maintain people's health.

Staff had received training about the Mental Capacity Act 2005 (MCA). However, the implementation of the MCA was not consistent. Restrictions imposed on people did not consider their ability to make individual decisions for themselves or their best interest as required under the Mental Capacity Act (2005) Code of Practice. People were not supported to have maximum choice and control of their lives.

The premises were not kept clean and the management of infection control was poor. Cleaning was not effectively planned or monitored. Areas within the service were dirty, there were unpleasant smells and the risk from infection from waterborne illness [Legionella] had not been minimised. Clinical waste bags were not sealed and removed from the premises to prevent the spread of infection. Poor cleanliness put people at the risk of harm from ingesting objects from the dirty floors.

The premises were not maintained to protect people's safety. The registered provider had not responded to urgent requirements for the repair of the electrical wiring in the service. Some parts of the service were run

down and dilapidated. Metal fire escapes had areas where they posed a trip hazard. Fire safety in the service was poorly managed. After the inspection we referred our concerns about fire safety to the Kent Fire and Rescue service.

The registered provider could not demonstrate that they were assessing and managing risk to the health, safety and welfare of staff who were there to provide care to people. They had consistently failed to meet the Health and Social Care Act 2008 and associated Regulations. There was no structure in place to ensure the registered provider looked at practice and improved standards of care being received by people.

The registered provider did not carry out robust audits to check the quality of care people received. The deputy manager carried out some audits, but these were not used to drive improvement. These audits had not always been effective at identifying and acting on the concerns we found during this inspection; such as, the shortfalls in care records and assessing risks.

The provider had reviewed policies including those that covered the planning of foreseeable emergencies. However, we found that some policies such as the policy on safeguarding people were not always followed. The policies in place to assist people if they wanted to make a complaint about the service did not meet published guidance for learning disability services.

People's right to do things for themselves was not always respected. People, were asked about their experiences of the service.

There were policies in place for the safe administration of medicines. Staff were aware of these policies and had been trained to administer medicines safely.

Recruitment policies were in place. Since our last inspection additional recruitment checks had been implemented before new staff started working at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During this inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities)

Regulations. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People in the service had not been protected from physical and emotional harm. Risks were not properly assessed and managed to keep people safe. People were not protected by a culture of learning from incidents.

The registered provider had not reported alleged abuse. Staff told us they knew how to recognise abuse, however we found a culture where staff may not recognised abuse when it happened.

The registered provider did not have adequate systems to assess the staffing levels required to meet people's needs safely. There were not enough staff available to meet people's assessed needs and manage the risks to people to protect them from harm.

Staff had not had appropriate training to manage challenging behaviours.

The premises were not maintained to protect people from potential harm.

Medicines were administered safely.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not fully assessed so that they received care based on their needs and choices.

The training did not fully equip staff with the skills they needed to provide safe person-centred care for people. Staff did not have sufficient knowledge to deliver care to people with learning disabilities.

People's capacity to make their own decisions had not been properly assessed. People were subject to restrictions and decisions had been made without staff implementing the best interest decision process.

People's health and wellbeing was not protected through the proper management of their nutritional and hydration needs. Staff did not always refer people to their GP or respond appropriately to recommendations made by external health care professionals.

Is the service caring?

Inadequate

The service was not caring.

Staff in the service did not fully understand how to care for people living with a learning disability or autism. People were not always involved in decisions about their care and treatment.

The registered provider had allowed an institutional culture to develop in the service so that the care was service led rather than person centred.

Privacy and dignity was not upheld by the provider as people in the service could not stop others from entering their bedrooms.

People's personal belongings were often taken by other people as they could not keep them secure.

Staff were friendly towards people but did not have time to interact or respond to people.

Is the service responsive?

Inadequate

The service was not responsive.

Care plan records were not fully updated following changes in people's needs or after an incident.

When people needed support from other professionals such as GP's, staff did not respond with any urgency so people's health needs were not met.

Complaints were recorded and had been responded to in writing. However, there was lack of information or assistance that made the complaints system accessible to everyone.

The opportunities for people to develop their goals, life skills and community participation, or take part in meaningful activities or occupation were limited.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider did not have systems in place to fully monitor and respond to risks.

The service did not reflect modern care for people with a learning disability.

The registered provider had not monitored the quality of care people received.

The registered provider did not encourage an open culture where incidents or issues of poor practise could be investigated and responded to.

People and their visitors were asked for their views about their experiences of the service.

The Old Rectory

Detailed findings

Background to this inspection

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

This inspection took place on 31 July 2018, 01 and 08 August 2018. The inspection was unannounced on 31 July and 08 August 2018 and announced on 01 August 2018. The inspection team on 31 July and 01 August 2018 consisted of three inspectors, and two inspectors returned to the service on 08 August 2018. The inspection was brought forward due to a number of concerns shared with us by the local authority in relation to people being unsafe, possible abuse and poor standards of care.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually 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. Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We took account of recent safeguarding information. We checked that the provider had followed their action plan.

We observed the care provided for people. 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 five people about their experience of the service. We spoke with seven staff including the registered provider, the deputy manager, two senior care workers and three care staff. We received feedback from two health and social care professional.

We looked at records held by the provider and care records held in the service. This included 13 care plans, daily notes; safeguarding, medicines and complaints policies; the staff recruitment records; the staff training programme; the staff rota; medicines management; complaints and compliments; meetings minutes; and health, safety and quality audits.

Inadequate

Is the service safe?

Our findings

One person said, "I feel safe because I've got friends here." Another person said, "The staff are very nice; they help me with showering, things like that." Another person said, "I am not happy here, staff give me horrible looks."

At our previous inspection 31 January and 1 February 2018, we found the registered provider was in a continued breach of Regulation 12 and was also in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made a recommendation about cleanliness and infection control.

At this inspection we found the registered provider had met Regulation 19. However, we found a continuing breach of Regulation 12, and we found breaches of Regulation 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People relied on staff and on the registered provider to keep them safe from harm; this had not happened. People had not been protected from abuse. There were serious failures to respond to allegations of abuse or to take steps to prevent abuse from occurring. There had been a recent allegation of abuse between people living at The Old Rectory. These allegations involved physical and emotional abuse. For example, people could go into other people's bedrooms and take their belongings and there had been an allegation that people had been exposed to inappropriate physical behaviour. The registered provider was aware of these concerns, but they had not taken appropriate action to protect people from harm. For example, a person's care plan record showed that they had a history of inappropriate physical behaviour towards others. The persons daily care records showed that they had a history of going into other people's bedrooms and taking their belongings. When the registered provider became aware of the concerns they failed to take robust measures to protect people from potential harmful behaviours.

The service had a safeguarding policy which set out the definition of different types of abuse, staffs responsibilities and the contact details of the local authority safeguarding team, to whom any concerns should be reported. However, it was custom and practice within the service to be dismissive of the impact of harmful behaviours and not always respond appropriately. For example, although we raised our concerns to the registered provider about the lack of monitoring and safety measures in the service, they told us that they thought the person going into other people's bedrooms was not a risk. Staff we spoke with did not take the concerns seriously and told us that the allegations were just hearsay.

The registered provider was aware that abuse was happening. However, their response put other vulnerable people in harm's way. For example, in response to concerns they moved people to new bedrooms without considering if doing so would expose people living nearby to potential abuse. There was a serious failure to recognise that people needed to be protected whilst allegations were investigated.

The registered provider had failed to effectively prevent potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

There had been a failure by the registered provider to learn from incidents and take appropriate step to keep people safe. For example, the registered provider recorded the concerns they had about the potential risks posed to others by a person's behaviours. These concerns had been raised by staff. This was recorded in the person's care plan on 29 June 2018. The registered provider had not investigated the incident to assess how this had affected the people involved. There were no incident records, or records that the local authority safeguarding team had been made aware of the concerns by the registered provider. Had there been a proper investigation and learning from this incident appropriate steps could have been taken to reduce risks.

We observed periods of time when there were no staff present, and people needed support. We found there were not enough staff to meet people's assessed and funded needs. During our inspection we observed that people were left for long periods without staff support. People were left for hours with food stained hands and clothing. Staff only responded to people who displayed challenging behaviours when the behaviours had already escalated to a higher level. For example, we observed one person throwing cushions and kicking a chair, the person only got a response from staff when they started to bang their hands on a glass window. Staff were not available to recognise to early signs that the person was becoming agitated and take action to avoid the behaviours becoming harmful. In another person's care plan was saw that speech and language guidelines were in place to reduce the risks of choking. The guidance stated 'the person must be in a supervised setting when eating and drinking'. We observed the person eating alone with no staff in the room. This meant that the person may choke and staff would not be on hand to respond.

There were not enough staff to maintain people's safety. One person was at risk of absconding from the service. Their care plan stated that staff 'must keep the person in line of sight at all times.' We observed that the person was left for long periods without staff being present. We asked the deputy manager about this. They told us that staff make a mental note of where the person is, if they go back and the person is not there they go and look for them. This meant that the staff practice did not match the recorded risks and control measures to protect the person from harm.

The registered provider had a dependency levels assessment tool. No assessment tool was in use to calculate how many staff were needed on each shift. Therefore, people's needs were not linked to the amount of staff in the service, this prevented staff from keeping people safe and meeting their needs.

The deputy manager gave us the staff hours they were funded for each person by the placing local authority. We checked the staff rota for July 2018 to see if the hours matched the funded hours provided to us by the deputy manager. We found that the service was under staffed by 369 hours per week. We also estimated that the daily care hours people were funded for should be 167 per day. However, on the July 2018 staff rota we found days where the planned staff hours were significantly less than this. For example, between 8am on Saturday 07 July 2018 and 9am on Sunday 08 July 2018 there were only 55 hours of care available. From 8am on Sunday 08 July 2018 to 9am and on Monday 09 July 2018 there were only 45 hours of care available. At these levels the service would struggle to provide even basic care to 31 people. The staff hours on the rota illustrated that the service was understaffed.

Three people needed staff supervision to maintain their safety. It was recorded in their care plans that they needed to be kept in line of sight of staff. We observed this was not happening. One member of staff told us, "I'm monitoring everyone", When we asked who they were monitoring they told us they were feeding one person, and supposed to be watching two other people. We observed that it was not possible for one member of staff to assist one person to eat in one room and observe two other people who were mobile and in a different rooms. This was a clear indication that the registered provider had not taken steps to deploy staff based on people's needs to keep people safe.

The registered provider had failed to deploy enough staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The registered provider had not fully assessed the individual risks people could be exposed to and provided clear guidance to staff so that safe working practices were followed. We found that risk assessments did not give detailed guidance about the levels of risks and how risks would be mitigated. Where risks had been identified, the action and control measure stated, 'staff to monitor.' However, risk assessments failed to say what staff needed to monitor, how the staff would monitor the risk and at what point the risk levels may change. For example, people using bedrails to minimise the risk of them falling out of bed were not risk assessed. The registered providers policy dated 26 January 2016 stated that staff should follow guidance issued by the Health and Safety Executive to avoid bed rail accidents. The policy stated a risk assessment should be carried out for bedrails and that the risk posed by bedrails can be fatal. We highlighted this to the registered provider during our inspection feedback on 01 August 2018. However, on 08 August 2018 we asked the deputy manager for evidence of how they were protecting people from the risks from the bedrails. They told us they had not looked at the bedrails and that there was still no risk assessment in place. This put people using bedrails at serious continued risk of harm.

Risk were not properly assessed and managed. Measures to protect people from serious injury were not being followed. At the previous inspection we found that people were not protected from the risk of choking. At this inspection we found that people continued to be at risk. For example, speech and language therapy guidelines were in place for a person at risk of choking when they ate. These guidelines stated that the person, 'must be in a supervised setting when eating and drinking'. We observed eating a meal alone with no staff in the room.

People were not protected from known risk. For example, some people required two staff to one person support for safety reasons. For one person their risk assessment dated 01 July 2018 stated that the person was to be escorted in a car, with two care staff supporting, and that the person was to be assisted to all appointments with two care staff. The risk assessment also confirmed that male care staff were not to be left alone with the person. During the inspection on 01 August 2018 we found that the person went out with one male carer and one other person who used the service. This exposed the person, other people and staff to harmful risks.

Risks management processes did not fully protect people from harm. Equipment was checked by an appropriate professional. For example, the fire detection systems and lifts were regularly serviced. However, health and safety checks within the service were not adequate. For example, we saw that several fire doors that were on automatic closers were wedged open with furniture or door stops. People or staff following an emergency exit sign above a bedroom door would not be led to an exit but could become trapped in the bedroom the fire exit sign led them into. We found three toolboxes left lying around in one corridor each containing tools and each unlocked. The fire evacuation procedure for each person directed staff to take people with mobility problems to two fire safety doors away from the fire. This would not be effective with some fire doors wedged open. We observed areas of the service's metal fire escape were dilapidated and parts of the metal sheeting on the landings were lifting causing a potential trip hazard. We shared our concerns about this with the Kent Fire and Rescue Service.

People were not protected from high levels of risk within the environment. The premises is a large Victorian house. We found no evidence the that risks from waterborne illnesses had either been assessed or fully mitigated. A water test had been carried out, but there was no Legionella risk assessment in place or a management plan for water tanks, plumbing, flushing or the monitoring of water outlets, placing people at high risk of infection. Without an assessment of the risks posed by the water system and the mitigating

actions required people were at higher risk of becoming unwell.

We also found that the electrical installation within the service building posed a risk to people. An electrician had inspected the electrical installation at The Old Rectory on 28 February 2018. The report stated there were eight faults that presented a 'danger present and a risk of injury' and, the electrician's report stated that 'immediate remedial action was required'. The report also highlighted 13 faults that were 'potentially dangerous' and required 'urgent remedial action'. The registered provider had not responded to the urgency of the risks posed by faulty wiring. This exposed people to potential death or serious injury.

At the previous inspection we found that the service was not consistently clean. We made a recommendation that the provider sought advice from a reputable source regarding ensuring the service is clean and the risk of infection prevented. During our inspection on 31 July and 01 August 2018 we found that the building was not clean. There were no records available that cleaning was planned or undertaken. Care plan records showed that people may eat objects from the floor. During the inspection we saw that the floors had not been vacuumed. We also saw, there were cigarette butts on the floor under a radiator, despite us finding that in a person's care plan they were at risk from swallowing cigarette ends. We observed a yellow clinical waste bag had been left outside the front door. The bag was not sealed and we saw that it contained soiled continence pads. Throughout the inspection parts of the building smelled offensive and particularly of urine.

Personal emergency evacuation plans (PEEP's) were in place. These identified the individual support and/or equipment people needed to be evacuated in the event of an emergency, for example a fire. Staff received training in how to respond to emergencies and fire practice drills were carried out to help keep people safe. However, there were no adaptations for people with hearing or sensory loss. Care plans stated that one person was deaf. However, their fire risks assessment dated 07 July 2018 stated that they were able to respond to the fire alarm. There were no recorded explanations as to how the person could hear the fire alarm. The person had not been provided with additional adaptations that would enable them to know if the fire alarm sounded. This lack of consistency clear guidance and adaptations to the person's needs placed them at risk.

The registered provider had failed to minimise risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We found that the building was not well maintained. Carpets throughout the service were worn and dirty: in some places the carpets were worn through. Paintwork was flaking off and chipped and some walls were badly chipped and some sections of skirting boards were missing. We saw that parts of the premises like windows had rotting frames.

The provider had a contingency planning policy. It included details about protecting people from the risk of service failure, due to foreseeable emergencies, so that their care could continue.

People were protected from the risk of receiving care from unsuitable staff. Since our last inspection the registered provider had introduced additional checks when staff were being recruited. For example, there was a new form for recording interview notes. The new policy protected people from new staff being employed who may not be suitable to work with vulnerable people. All applicants for jobs were checked against the Disclosure and Barring Service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with vulnerable people. Before employment, all job applicants were asked to explain in full any gaps in their employment history. New staff could not be offered positions unless they had provided proof of identity, written

references, and confirmation of previous training and qualifications.

Staff administered medicines safely. Training and updates about medicines was provided to staff. The deputy manager has assessed staff competency by observing their practice. A medicines policy was in place and was understood by staff administering medicines. Medicines management audits had been completed. When changes in medicines had occurred, staff had updated the medicines administration records accordingly (MAR).

Medicines were stored safely and securely in a locked clinical room. Fridge and room temperatures were recorded by staff daily and were within normal temperature ranges so that medicines would remain safe and effective.

Inadequate

Is the service effective?

Our findings

One person said, "The staff are going to ring the doctor for me tomorrow. They ring up and take me there." Another person said, "It's gone downhill here." Another person said, "I like the food. Stew and lamb. I like it all."

Following a recent visit to the service a health and social care professional told us, "There were 26 other residents in the dining area. Staff were bringing in food and plonked it down in front of people without speaking to them. People found to it difficult to get the attention of staff to get more to drink, which was concerning as it was a hot day."

At our previous inspection 31 January and 1 February 2018, we found the registered provider was in a continued breach of Regulation 13 and was also in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the registered provider had not made the improvements needed to meet the regulations. We found continuing breaches of Regulation 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 9, 11, 12 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a concern that people's health and wellbeing was not being protected by staff. During the inspection on 31 July 2018 and 1 August 2018, a person stayed in bed under the duvet. Temperatures within person's bedroom were checked by the deputy manager on our request and were recorded at 24 degrees. The doors to the person's room were closed and there was no ventilation. This person was left in bed, there were no records of regular checks on them when they stayed in bed. There were inconsistent records on food offered at meal times. There were records of drinks being offered at meal times but no records of how much the person drunk or ate. There was no recorded information of fluids offered between meal times to the person. Records showed that the person often remained in bed. For example, on 21, 25 and 27 July 2018; the person's care logs showed that they stayed in bed. They were offered fluids at meal times but there were no consistent records of food being eaten or what they drank. On 27 July 2018 there was no food recorded for this day.

There was no benchmark information based on a person's body mass index (BMI). (The BMI is an attempt to quantify the amount of tissue mass (muscle, fat, and bone) in an individual, and then categorise that person as underweight, normal weight, overweight, or obese based on that value). Although people had been weighed, this was inconsistent with gaps in the records. One person had lost weight in the period up to May 2018, but had not been weighed since. We asked the deputy manager to weigh the person during the inspection. The person had lost more weight since May 2018. However, the deputy manager did not know if the persons current weight was a risk to their health. No referral had been made to the person's GP to review this concern.

People's health and welfare was not supported through their nutritional and hydration needs being met and

not all people received adequate food and drink to meet their health needs. On 31 July 2018 we observed a person being offered one type of supper (a sandwich) and shaking their head to refuse it. We saw that staff offered nothing else to eat to the person. This person was just left with a drink. One member of staff asked the person if they were alright and the person shook their head, there was no follow up action by the member of staff. We then observed the person was removed from the dining table without eating any food.

There was not a structured approach to measuring how much people had eaten or drunk. Some people had food and fluid charts because they were at risk of malnutrition or dehydration, or were losing weight. However, there were no recorded intake targets for people and no total on the monitoring charts meaning they were not effective. There was a four week menu but no indication that people had chosen this and the picture board to display the menu was not being used. Food and fluid intake was being recorded on a day to day basis, but did not show how much people had eaten or drank. For example, staff just recorded, 'Breakfast: Cereal. Lunch: fish fingers, chips, spaghetti and mousse. Tea: Sandwich.' It would not be possible to find out if a person had been missing meals or eating less from the care records. This put the health of people who were already assessed as requiring assistance to eat and drink at higher risks.

One person's care plan stated that they were at risk of malnutrition and dehydration and needed prompting. It stated the person would not ask staff for a drink if they were thirsty. There was no monitoring of the persons fluid and food beyond the basic recording in the daily notes. There were records of fluid offered at meal times but no records of how much the person drunk or ate. There was no recorded information of fluids offered between meal times, including during a period of very hot weather. There was no information in the person's risk assessment regarding malnutrition and dehydration. The persons health action plan stated that 'X is able to eat and drink independently.'

One member of staff told us, "I'm monitoring everyone", When we asked who they were monitoring they told us they were supporting one person to eat, and supposed to be watching two other people. We observed that it was not possible for one member of staff to deliver care and observe two other people. One of the people that the member of staff was watching was at times in a different room and walking around.

During the breakfast service on 31 July 2018 we observed 14 people being supported by the cook who was rushing to get toast on to people's plates without seeming to offer choice or stopping to talk to people. A member of staff told us that there were only two care staff that day for 31 people. Some people required two staff to support them with personal care and moving and handling tasks. During the lunch service on the 31 July 2018 there was one member of staff in the room caring for 20 people for most of the meal service. As a result there was not enough support to encourage people to eat and to serve food and drink in a personalised way and as a result food was placed carelessly and in a rushed manner on to people's plates.

The registered provider had failed to provide suitable food and hydration based on people's needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Staff had been receiving updates to their training in subjects such as first aid and moving and handling. However, at our last inspection we found staff were not fully trained to meet people's individual needs. The registered provider had told us in their action plan that they would provide training to staff in learning disabilities and positive behaviour support / de-escalation training for the management of challenging behaviours. However, at the time of this inspection this training had not been provided. Staff told us of incidents when people had become distressed and physically aggressive. Without the appropriate training people and staff were at risk of harm. For example, staff would not understand the reasons for people's behaviours and how to support them to manage their distress.

The registered provider had consistently failed to ensure that staff were fully trained to be able to complete their roles effectively. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (2005) 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. The application procedures for this in care services and hospitals are 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 were being met.

People were not being supported in line with the MCA. One person had bed rails in place to prevent them from rolling out of bed and being injured. There was no mental capacity assessment to check if the person understood the need for bed rails. The person had a document in their care plan that stated they were unable to make decisions around medical treatments, but no best interest decision about the use of bed rails was recorded. We asked the deputy manager for copies of any mental capacity assessments for the person but there were not any.

The registered provider had failed to gain people's consent to treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights were not protected. A person had been deprived of their liberty through a deprivation of Liberty authorisation (DoLS) dated 01 May 2018. The DoLS was in place because the person needed constant supervision by staff. The DoLS authorisation had conditions which included as far as possible, that the person's whereabouts were always known by staff. During our inspection on 31 August 2018, we observed the person being left unobserved by staff on a number of occasions for periods of time. On day two of the inspection, 01 August 2018 we carried out a 30 minute observation of the person. During this time staff did not constantly provide supervision to the person. There were times when staff went outside to smoke and we found that from their position that they could not observe the person.

The registered provider had failed to protect people's rights. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs had not been suitably recorded which resulted in people's health needs not being met. One person's health action plan stated that they were independent with eating and drinking. There was no mention of the person's speech and language therapy (SALT) guidance which was recorded in their health action plan. The SALT guidance stated that the person required their food prepared in a certain way to reduce the risk of choking. The person's health action plan made mention of a serious mental health condition. This was not recorded in the persons care plan to give guidance about how staff manage this. In addition, the person had a medical condition that affected one side of their body; however, this was not described or accounted for in their mobility plan.

Another person's care plan referenced the fact that their mobility had decreased due to a fall. However, their mobility guidelines had not been updated and still described supporting the person with a walking aid, whereas staff had been supporting the person with a wheelchair since the fall. The registered manager contacted other services that might be able to support them with meeting people's health needs. This

included the local GP, the community nursing teams, occupational therapist. However, recommendations made by heath care professionals were not always implemented.

The registered provider had failed to ensure that care plans and assessments met people's health and welfare needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care we observed did not always match people's assessed needs. Care plans made reference to promoting independence. However, people were not supported to increase their independence and enhance their daily living skills. For example, one person's care plan stated that they required full assistance with the preparation on all meals to ensure a healthy balanced diet. The person's risk assessment stated that the person was to be encouraged to help staff in the kitchen with one to one support. There was no evidence that this person or anyone else was encouraged to help in the kitchen. The person told us "No, I don't get to cook." People were able to participate in managing their own laundry with staff support. Instead we observed people's laundry was collected and washed communally by staff. We observed people taking their washing to the laundry room. One person said, "Staff do the laundry."

The registered provider had failed to deliver care in a person-centred way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Areas in the service were adapted for wheelchair access, for example there were ramps to access the garden. People living on the upper floors could access a lift to move between floors. However, the overall design and adaptation of the building did not meet people's needs. There were lots of interlinking corridors that could be confusing to people with learning disabilities and cognitive impairments such as early onset dementia.

Bedroom doors were the same colour with little or no signage to assist people to orientate themselves. The building was not decorated in a personalised way and sections of the building were decorated by with collections of the registered providers hobbies and interest such as various tins, model cars and other memorabilia personal to the registered provider. There was no evidence of people's involvement in the decoration of the service. Some areas of the service such as the games room next to the dining room were cluttered and appeared to be being used for storage.

No new staff had been recruited since our last inspection. However, the systems in place supported new staff to an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. New staff worked through the Care Certificate standards. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

The deputy manager checked how staff were performing through an established programme of regular supervision (one to one meeting) and an annual appraisal of staff's work performance. The deputy manager kept a record of the discussions they had with staff and had a plan in place to make sure that staff supervisions took place. Supervision is a process, usually a meeting, by which an organisation provided guidance and support to staff. Staff told us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings.

Inadequate

Is the service caring?

Our findings

At our previous inspection 31 January and 1 February 2018, we found the registered provider was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 Care Quality Commission (Registration) Regulations 2009.

At this inspection we found the registered provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The registered provider was unable to demonstrate that they were appropriately assessing, auditing and managing risk to the health, safety and welfare of people living at the service. At our last inspection registered provider's governance systems had not picked up the issues we found at that inspection and had not identified continued and new breaches of fundamental standards and regulations. At this inspection we found this was still the case. For example, we continued to find poor risk management processes and people continued to be at risk of choking or neglect. This meant that there was an increasing risk to people. The provider had failed to complete improvements in line with their own action plans.

There have been four previous CQC inspections dating back to March 2016 where serious concerns and breaches of regulation were identified. Since March 2016 we have found breaches of Regulations in relation to risks and hydration and nutrition. The registered provider had not met Regulation 12 Safe Care and Treatment since 21 March 2016.

We found that the registered provider could not consistently meet their legal duty to comply with the Health and Social Care Act 2008 Regulations. We found evidence that the culture in the home was institutional and not focused on person centred care.

We found that staff and the registered provider were dismissive of potential risks of harm. The local authority safeguarding team had made the registered provider aware of concerns they had received about allegations of abuse in the service. Staff were asked to monitor the people involved more closely. However, staff had not taken the allegations seriously. For example, we spoke to staff about the fact they were monitoring a person more closely. One member of staff said, "I know the reason (for the monitoring) but I think it is stupid nonsense." The registered provider said, "I feel that the client was being victimised by safeguarding, the police and CQC and that an innocent man is being railroaded." He also told us he was not worried about X as he doesn't think that there is a risk.

Management audits within the service were not robust. Audit sheets were very basic, they did not show the detail of what had been audited or if the audit was satisfactory or if there were any action. For example, it just stated kitchen audit or health action plans. The audit sheets had a name, signature and date but included no other information such as what was found or what action was taken. There were no explanations for gaps on the audit sheets. For example, the audit sheet for week commencing 23 July 2018 had not been completed for the Thursday and Friday of that week. There were no effective systems in place

to ensure that the maintenance and safety of the premises were kept up to date. For example, the portable appliance testing was due to be completed in March 2018. This had not been picked up by the audit systems and the registered provider was not aware of this until we pointed it out to them. This meant that quality and safety issues within the service were not picked up and people's records were not kept up to date.

The registered provider had been unable to demonstrate that they could proactively manage their own quality systems in the service. They relied heavily on external agencies to tell them how to respond to risk or how to make improvements. For example, the local authority had raised a serious safeguarding concern with the registered provider in June 2018. At the request of the local authority the registered provider put an alarm on a person's bedroom door to alert staff if they left their bedroom as others may be at risk. However, the registered provider had not checked that the alarm they installed could be heard by staff, nor had they taken into account the fact the person could leave their bedroom via another exit which was not alarmed. They were not aware of this until we pointed this out during our inspection. The registered provider had a dependency tool, but did not know how to use it. They were waiting for advice about this from an external consultant. This meant that they had failed to provide enough staff.

In 2015 NHS England, the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA) published 'Building the Right Support' (BRS). BRS developed a new national service model for learning disability services. CQC in their response to this published the Registering the Right Support guidance for inspections. We found that the service was not delivered in accordance with this guidance. In that the observed care and the environment internally was very institutional, assessments and care plans did not support person centred care. Staff had not received the levels of training and guidance needed to deliver a service that met current practice and published guidance.

The registered provider had failed to assess, monitor and improve the quality of the services provided and reduce risks to people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a systemic failure by the registered provider to ensure that incidents involving acts of abuse or neglect were reported to the local authority or to CQC so that they could be investigated and steps taken to prevent abuse. For example, the registered provider recorded the concerns they had about potential abuse in a person's care plan on 29 June 2018. However, there were no incident records, notifications or records that the local authority safeguarding team had been made aware of the concerns.

The registered provider had failed to report incident which impacted on people's health, safety and welfare to CQC. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider's quality assurance system included an annual questionnaire asking people, relatives, staff and healthcare professionals about their experience of the service. The questionnaires asked people what they thought of the care. The last questionnaire had been completed prior to our last inspection and was next due in September 2018.

There was a range of policies and procedures that were now specific to this service governing how the service needed to be run. The policies were updated with new developments in social care. For example, we saw a new policy had been put into place covering the General Data Protection Regulations 2018. A new law on data protection and privacy for all individuals.

However, we found that the registered provider was not following their policies. For example, their policy

called 'Service Users with Communication difficulties' stated 'Using appropriate and effective communication is a fundamental part of treating people with dignity and respect and in providing good, compassionate care. The organisation believes that all service users have the right to have their needs fully assessed and for a personalised, individualised plan of care to be developed that places them at the centre of their care.' This had not been implemented by the service.

The policies were designed to promote good quality safe care. However, this could not be achieved as the registered provider was not following their policies about safeguarding people and managing risk or person centred care.

Staff told us that the registered provider and deputy manager had an 'open door' policy which meant that staff could speak to them if they wished to do so and the deputy manager worked alongside staff as part of the team. One member of staff said, "The managers are very approachable." Another member of staff said, "The deputy manager is very supportive and the registered provider is approachable."

The registered provider worked with social workers, referral officers, occupational therapists and other health and social care professionals when needed. For example, the registered provider had worked closely with the community mental health team when assessing a person's mental health care needs. The registered provider had used external agencies to assists with the planning the management of medicines.

It is a legal requirement that a provider's latest CQC inspection report 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 judgements. The provider did not have a website, but had displayed their rating in the reception office of the service.

Inadequate

Is the service responsive?

Our findings

One person said, "It is boring here, there is nothing to do, especially at weekends." And "I'm not allowed to complain." Another person said, "I am going out tomorrow. Staff will take me to my relatives and then my relatives will take me out."

At our previous inspection 31 January and 1 February 2018, we found the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made recommendations about complaints and end of life care.

At this inspection we found the registered provider had not made the improvements needed to meet the regulations. We found a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had met one of the recommendations relating to the management of end of life care.

Peoples care was not based around their needs and choices. People could be supported to participate in managing their own laundry. Instead we observed people's dirty laundry was collected communally and washed communally by staff. Staff told us they did the washing for people. For much of our time on site, people were not occupied and we observed people being left for long periods without communications with others. We observed people hanging around in corridors, sitting for hours alone at tables and one person was rocking back and forward in their chair.

Person centred reviews were not taking place. People had health action plans, but these were not being kept up to date. For example, the deputy manager told us that people had seen the dentists. However, the information about people seeing the dentist in their health action plans was not up to date. (Health action plans are recommended for people with learning disabilities by the department of health to promote people's health and their access to health services).

Communication passports were not in place. (Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services). For example, if they were admitted to a hospital. We spoke to a visiting healthcare professional about people's communication and were told, "X's speech is quite slurred and I spoke to the service about having a communication passport. There isn't one and I don't' think they [staff] understood the importance of having one."

There was no evidence to show that people were actively involved in the review of their care plans. The care plans were written in a standard format with no use of pictures or assistive technology communication tools such as electronic tablets. The font used in care plans was small and the deputy manager confirmed that the only accessible adaptations to care plans were some basic pictures in health action plans. These pictures were of, e.g. a nurse at the top of the page, but did not relay the contents of the plan in an accessible way. This meant that people the plans were about could not easily understand them.

Activities were not person centred or varied. We noted from one person's daily records that between 01July 2018 to 20 July 2018 that there had been one occasion where the they 'relaxed in the garden' and another occasion where they had 'engaged with arts and crafts.' However, all other records for the 20 day period recorded that they watched TV in their bedroom. Another person's daily notes for 34 days between 21 July 2018 and 18 June 2018 (inclusive) showed that the person had not been out of the service and into the community for that whole period of time. One entry on 21 July 2018 recorded they had been in the garden. Activities were poor. From 07 July 2018 to 20 July 2018 there was a 14 day period where there were no recorded activities for one person. There were multiple consecutive days where the records showed one person was just left in the lounge and conservatory with no stimulation. We observed over the three days of our inspection the same person was left for long periods at the same table without interaction. However, in the person's care plan it stated, "One to one staff to encourage and assist me to participate in activities. One to one staff to take me for a drive." Staff were not meeting people's welfare needs.

There were not enough activities to keep people occupied in a meaningful way. There was not a structured approach to activities. We asked what activities were provided and were informed that there was arts and crafts twice a week and music once a week. Some people also attended a sports evening. There was no activities planner, and no clear record of the activities that people did and enjoyed and how long they participated. There were no clear links between the activities they did and any records of what people would like to do. The only reference to activities was in the people's daily notes which included, for example, colouring in the lounge, but did not provide any detailed feedback or analysis to show if people actually enjoyed the activities.

Staff told us they discussed people's hopes and dreams with them and agreed goals that people may want to achieve. The deputy manager said, "We do talk to people about their aspirations and goals, and record these in the care plans. We have new care plans." However, there was no documented evidence to indicate that this approach was planned, recorded and delivered. For example, a person's care plan included hopes and dreams. The goal identified was 'one day when she is better to go to Disney land' The action/ support was, 'staff to remind the person of her dream of going to Disney land. Care staff to liaise with parents.' There was no more information about a plan to achieve this goal.

The registered provider had a complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. However, the complaints information was not meeting the Accessible Information Standard. Complaint and care plan documentation was not written in a way that people could understand. The accessible information standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss.

The registered provider had failed to ensure that people's care met their needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff were in the process of recording information about people's wishes and choices for their end of life. However, these had yet to be fully completed. However, where these were completed people had support plans in place to enable them to die in a pain free and dignified manner at the end of their lives. There were 'When I die' booklets in people's care files. These looked at areas such as religion and any priest or religious practitioner to be contacted in the end stages of a person's life. People could identify a next of kin or advocate to be contacted and people could choose where to be cared for at the end stage, such as in their

home, or at hospital. One person had identified which family members they wanted to be present for their death and had chosen cremation at a local crematorium. They had identified music they would like to be played during their funeral service and an object of importance to be placed inside the coffin with them. The person had recorded how they would like to be dressed inside the coffin stated what colour clothes, as this was their favourite colour.

Inadequate

Is the service well-led?

Our findings

At our previous inspection 31 January and 1 February 2018, we found the registered provider was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 Care Quality Commission (Registration) Regulations 2009.

At this inspection we found the registered provider remained in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The registered provider was unable to demonstrate that they were appropriately assessing, auditing and managing risk to the health, safety and welfare of people living at the service. At our last inspection registered provider's governance systems had not picked up the issues we found at that inspection and had not identified continued and new breaches of fundamental standards and regulations. At this inspection we found this was still the case. For example, we continued to find poor risk management processes and people continued to be at risk of choking or neglect. This meant that there was an increasing risk to people.

There have been four previous CQC inspections dating back to March 2016 where serious concerns and breaches of regulation were identified. Since March 2016 we have found breaches of Regulations in relation to risks and hydration and nutrition. The registered provider had not met Regulation 12 Safe Care and Treatment since 21 March 2016.

We found that the registered provider could not consistently meet their legal duty to comply with the Health and Social Care Act 2008 Regulations. We found evidence that the culture in the home was institutional and not focused on person centred care.

We found evidence that staff and the registered provider were dismissive of potential risks of harm. The local authority safeguarding team had made the registered provider aware of concerns they had received about allegations of abuse in the service. Staff were asked to monitor the people involved more closely. However, staff had not taken the allegations seriously. For example, we spoke to staff about the fact they were monitoring a person more closely. One member of staff said, "I know the reason (for the monitoring) but I think it is stupid nonsense." The registered provider said, "I feel that the client was being victimised by safeguarding, the police and CQC and that an innocent man is being railroaded." He also told us he was not worried about X as he doesn't think that there is a risk.

Management audits within the service were not robust. Audit sheets were very basic, they did not show the detail of what had been audited or if the audit was satisfactory or if there were any action. For example, it just stated kitchen audit or health action plans. The audit sheets had a name, signature and date but included no other information such as what was found or what action was taken. There were no explanations for gaps on the audit sheets. For example, the audit sheet for week commencing 23 July 2018 had not been completed for the Thursday and Friday of that week. There were no effective systems in place to ensure that the maintenance and safety of the premises were kept up to date. For example, the portable

appliance testing was due to be completed in March 2018. This had not been picked up by the audit systems and the registered provider was not aware of this until we pointed it out to them. This meant that quality and safety issues within the service were not picked up and people's records were not kept up to date.

In 2015 NHS England, the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA) published 'Building the Right Support' (BRS). BRS developed a new national service model for learning disability services. CQC in their response to this published the Registering the Right Support guidance for inspections. We found that the service was not delivered in accordance with this guidance. In that the observed care and the environment internally was very institutional, assessments and care plans did not support person centred care. Staff had not received the levels of training and guidance needed to deliver a service that met current practice and published guidance.

The registered provider had failed to assess, monitor and improve the quality of the services provided and reduce risks to people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a systemic failure by the registered provider to ensure that incidents involving acts of abuse or neglect were reported to the local authority or to CQC so that they could be investigated and steps taken to prevent abuse. For example, the registered provider recorded the concerns they had about potential abuse in a person's care plan on 29 June 2018. However, there were no incident records, notifications or records that the local authority safeguarding team had been made aware of the concerns.

The registered provider had failed to report suspected abuse. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider's quality assurance system included an annual questionnaire asking people, relatives, staff and healthcare professionals about their experience of the service. The questionnaires asked people what they thought of the care. The last questionnaire had been completed prior to our last inspection and was next due in September 2018.

Staff told us that the registered provider and deputy manager had an 'open door' policy which meant that staff could speak to them if they wished to do so and the deputy manager worked alongside staff as part of the team. One member of staff said, "The managers are very approachable." Another member of staff said, "The deputy manager is very supportive and the registered provider is approachable."

The registered provider worked with social workers, referral officers, occupational therapists and other health and social care professionals when needed. For example, the registered provider had worked closely with the community mental health team when assessing a person's mental health care needs. The registered provider had used external agencies to assists with the planning the management of medicines.

There was a range of policies and procedures that were now specific to this service governing how the service needed to be run. The policies were updated with new developments in social care. For example, we saw a new policy had been put into place covering the General Data Protection Regulations 2018. A new law on data protection and privacy for all individuals.

However, we found that the registered provider was not following their policies. For example, their policy called 'Service Users with Communication difficulties' stated 'Using appropriate and effective communication is a fundamental part of treating people with dignity and respect and in providing good, compassionate care. The organisation believes that all service users have the right to have their needs fully

assessed and for a personalised, individualised plan of care to be developed that places them at the centre of their care.' This had not been implemented by the service.

The policies were designed to promote good quality safe care. However, this could not be achieved as the registered provider was not following their policies about safeguarding people and managing risk or person centred care.

It is a legal requirement that a provider's latest CQC inspection report 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 judgements. The provider did not have a website, but had displayed their rating in the reception office of the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to minimise risks and to ensure that care plans and assessments met people's health and welfare needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The enforcement action we took:

We imposed the following condition; The registered person must not admit any new service users to The Old Rectory, 45 Sandwich Road Ash, Canterbury, CT3 2AF without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to effectively prevent potential abuse and had had consistently failed to protect people's rights. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The enforcement action we took:

We imposed the following condition; The registered person must not admit any new service users to The Old Rectory, 45 Sandwich Road Ash, Canterbury, CT3 2AF without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to provide suitable food and hydration based on people's needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The enforcement action we took:

We imposed the following condition; The registered person must not admit any new service users to The Old Rectory, 45 Sandwich Road Ash, Canterbury, CT3 2AF without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess, monitor and improve the quality of the services provided and reduce risks to people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed the following condition; The registered person must not admit any new service users to The Old Rectory, 45 Sandwich Road Ash, Canterbury, CT3 2AF without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to deploy enough staff to meet people's needs and consistently failed to ensure that staff were fully trained to be able to complete their roles effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The enforcement action we took:

We imposed the following condition; The registered person must not admit any new service users to The Old Rectory, 45 Sandwich Road Ash, Canterbury, CT3 2AF without the prior written agreement of the Care Quality Commission.