Life Opportunities Trust

186-188 Lowdell Close

Inspection report

186-188 Lowdell Close
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11 October 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Life Opportunities Trust - 186-188 Lowdell Close is a care home providing personal care for up to four adults with learning and physical disabilities. Four people were using the service at the time of the inspection.

Services for people with learning disabilities and/or autism should be developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The principles and values are to ensure people who use the service can live as full a life as possible and achieve the best possible outcomes. They reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the services should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
Relatives of people using the service told us, "Generally, it's not a bad home but it's not the same as it was." Relatives said the quality of the service had declined since the last inspection. They felt this was because of staffing issues and people not being supported to go out and about very much.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support. This is because people were not treated with dignity and respect at all times. There had been some improvements in supporting people to participate in activities, but some people were not always supported to help them experience good, meaningful everyday lives. This was in part because the provider had not consistently deployed enough sufficiently trained and competent staff to meet people's needs effectively at all times.

The service did not have robust arrangements to ensure people always received positive behaviour support in line with good practice guidance. Staff were caring with people but did not always promote good communication with them.

The provider engaged temporary agency staff to cover support worker vacancies. They arranged for the same agency staff to attend so people could be supported by people they were familiar with. Medicines were not always managed appropriately and incidents and accidents were not recorded consistently, which could put people at risk of poor care.

The provider's systems for identifying, assessing and mitigating risks to people's well-being and the quality of the service had not always been operated effectively.

People were not always supported to have maximum choice and control of their lives. However, staff did support them in the least restrictive ways possible and in their best interests. Policies and systems in the service promoted such practice.

There were systems to safeguard people from the risk of abuse and to prevent and control infection. There were fire safety arrangements in place.

The provider operated suitable recruitment procedures designed to ensure only 'fit and proper' staff were employed at the home.

The provider had improved the home environment by ensuring mobility and bathing equipment had been repaired, decorating some areas and ensuring the garden was more accessible to people.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 5 June 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations. The service remains rated requires improvement.

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

Enforcement
We have identified breaches in relation to person-centred care, staffing, safe care and treatment and good governance at this inspection.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not 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

186-188 Lowdell Close

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
One inspector conducted the inspection on 10 and 11 October 2019.

Service and service type
Life Opportunities Trust - 186-188 Lowdell Close 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 did not have a manager registered with the CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The operations manager was planning to apply to the CQC to be the registered manager of the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included the action plan the provider sent to us following the last inspection saying what they would do and by when to improve. We received feedback from the local authority. We reviewed information about important events the provider had notified us about what had happened at the service. We used all of this information to plan our inspection.

The provider was 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. However, the inspection visits took place before the date by when the provider needed to send this information to us. The provider sent us this shortly afterwards.

During the inspection
During the inspection we met four people who lived at the service. The people had complex needs and could not describe to us how they felt about living at the service. 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 four support workers, a senior support worker, the service manager, and the provider's operational manager. We looked at the care plans for two people, medicines support records and a variety of records relating to the management of the service.

After the inspection
We continued to seek further information and clarification from the provider to validate evidence found. We spoke with another relative and two adult social care professionals who have worked with the service.

Requires Improvement

Is the service safe?

Our findings

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

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

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our last inspection the provider had failed to deploy enough staff 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At the last inspection we found the provider had arranged minimum levels of staffing which kept people safe but did not enable staff to support people to go out or spend meaningful time with people at home. We found the provider had made some improvements by increasing staffing levels from two to three support staff working some morning-to-afternoon and afternoon-to-evening shifts. The manager explained when they were at the home they could also provide additional care and support if required. However, we found the increased staffing did not always take place consistently.
● Staffing rotas for the five weeks up to our visit indicated only two staff and no additional manager support had been arranged to work on 19 occasions, over a quarter of the scheduled occasions over this period of time. Relatives who visited regularly also told us the level of staffing meant staff could not spend long with individuals. One relative said, "[With] only two staff on they've not really got much time to interact with them."
● Managers told us an extra staffing shift had recently been added to the staff rota, to provide more support to people. However, rotas for the five weeks up to our visit showed an extra shift had only been arranged on four occasions.
● At the last inspection there were a number of staff vacancies and so temporary staff were sourced from an employment agency. This was still the case, but recent staffing rotas showed the same agency staff were now being engaged regularly to work at the service. The manager told us this helped people to be supported by staff who they could get to know them. One relative stated, "Some agency staff are good, they have been coming a long time." Some relatives, though, told us this had not always been the case since the last inspection. Their comments included, "So many different [staff] coming in, lots of agency. Sometimes lots of new faces, it must be the same for the residents," and, "I would like them to have more regular staff here, to get to know [the people] and all the little habits they have."
● An adult social care professional said changes in staffing over the year meant they had not always received accurate records of people's seizures. This meant it had been more difficult for them to determine

how well the person's medicine was working for them.

The above shows the provider had not consistently deployed enough staff to meet people's needs effectively. This placed people at risk of not always receiving care to meet their needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed these staffing issues with the managers who explained actions being taken to improve staff consistency. These included ongoing permanent staff recruitment, contracting agency staff to provide regular fixed hours, and recruiting a new member of staff to work during the day who could drive the house vehicle, meaning people could be supported out more often. We observed the operations manager working on this recruitment during our inspection visit.
● Staff recruitment records showed the provider completed necessary pre-employment checks so they only offered roles to fit and proper applicants.

Using medicines safely
● Some people were at risk of not always receiving their medicines as prescribed.
● One person was recently prescribed a 'rescue' medicine to treat seizures. This medicine can be used for urgent treatment and can stop or reduce a person's seizure or provide more time for emergency services to respond to them. Records showed staff administered this to the person in the month before our inspection. While the member of staff had been trained in how to administer this medicine, there was no written protocol or guidance in place for staff on how and when to do this safely. This was not in line with National Institute for Health and Care Excellence (NICE) guidance for managing medicines in care homes, nor the advice of epilepsy healthcare specialists. We discussed this with the managers who acknowledged guidance needed to be in place and said they would address this.
● Staff supported one person to take their medicines with some food. The manager explained the medicine was visible and staff told the person about it so they could choose to refuse it. This arrangement was clearly set out in the person's care plan. However, there were no directions from a healthcare professional on whether it was safe to mix the medicines with food, as this can affect the properties of some medicines.
● This person was prescribed a medicated cream, but for over two weeks staff had not indicated correctly on medicines administration records (MARs) if the person had been supported to use this or not. This meant it was not clear if they had received their medicines as prescribed. We discussed this with the managers who acknowledged the MARs should clearly indicate the medicines support provided and said they would address this.

We found no evidence that people had been harmed however, this indicated medicines support was not always managed in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other MARs we reviewed set out the necessary information for the safe administration of people's medicines and staff had completed these records appropriately. We saw there was clear information for staff on how people liked to be supported to take their medicines.
● People's medicines were stored securely in cabinets in their bedrooms. These cabinets were clean and tidy and records of the amount of medicines held were up to date and correct.
● Staff had medicines training and the service manager had assessed staff competency in medicines support. This included agency support worker who worked at the home regularly.
● People were prescribed medicines to be given 'when required'. 'When required' medicines are those given only when needed, such as for pain relief. There were written protocols in place to guide staff on when they

should support a person to take such medicines.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider did not always assess and manage risks to people's safety and wellbeing so they were supported to stay safe.
● People had risk management plans in place to reduce risks to their safety and well-being, but these were not always up to date to reflect current risks to people. For example, the guidance for staff on supporting a person who experienced epileptic seizures had not been updated to include reference to the person's prescribed 'rescue' medicine.
● The provider had systems in place for recording and responding to incidents and accidents, but these were not being used consistently at the time of our inspection.
● A daily record of one person's care noted they had recently experienced an injury to their hand. Staff were aware of this. However, there was no further record of this incident to indicate if it had been responded to and investigated appropriately, nor if steps were needed and taken to help make sure it didn't happen again.

We found no evidence that people had been harmed however, these issues indicated people were at risk of harm as known risks to their safety or incidents that affected people's welfare were not always managed effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risk management plans for supporting people to be safe from the risk of harm addressed issues such supporting people to use mobility equipment, using portable heaters and bathing. Records showed these were up to date and checked regularly.
● One person's care and risk management plans identified staff needed to prepare food to a suitable consistency to protect the person from the risk of choking. There was guidance for staff on how to do this based on speech and language therapists' advice. However, the guidance did not always use the current International Dysphagia Diet Standardisation Initiative standardised ways of describing food textures to promote safe care. We discussed with operations manager and they say they would address this.
● The provider conducted appropriate assessments of the environment to make sure this was safely maintained. These included checks on equipment, water, gas and electrical safety.
● The provider had arrangements in place to protect people from the risk of fire. These included a fire risk assessment and an action plan to address issues this identified, fire equipment checks, and regular evacuation practices at different times of the day. People had personal evacuation plans, although the manager told us new staff needed to complete training on how to use the evacuation equipment. The provider did not provide evidence that staff who had been in post for a longer period of time had completed this training when we requested this.
● There was a 'grab bag' to be used in an emergencies which held up to date information about people and their prescribed medicines. We discussed the fire safety evacuation plan with the manager and they updated this during the inspection to better show where the home's evacuation points were.

Systems and processes to safeguard people from the risk of abuse
● Staff completed training on safeguarding adults. Staff we spoke with knew how to recognise and respond to safeguarding issues. They felt they would be listened to by managers if they reported such concerns.
● We saw the records of when staff handled people's money were checked regularly to help protect people from the risk of financial harm.
● Managers had engaged in safeguarding processes led by the local commissioning authority to respond to safeguarding concerns.

Preventing and controlling infection

- There were arrangements for preventing and controlling infection.
- Staff were provided with gloves and aprons and told us there were always supplies of these for them to use.
- Staff described to us the daily cleaning schedule to keep the environment clean and prevent infections.

The home appeared clean during the inspection and relatives also told us the home was kept clean.

Requires Improvement

Is the service effective?

Our findings

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

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

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The service did not always provide people with positive behaviour support in line with good practice guidance.
- The service supported some people who had a tendency to behave in ways others may find challenging. We saw there were risk management plans regarding how a person may act when distressed and support guidelines for staff to follow at these times. However, these guidelines did not set out proactive strategies to help the person to reduce the likelihood that situations escalate and to minimise risks to the person and others.
- The person's risk management plans required staff to record observations regarding their behaviour at these times, for analysis to identify learning about how to improve support to the person. The most recent observation records were from June 2019, over three months before our inspection visit. This meant the provider did not ensure the person's behaviour was monitored and supported effectively.
- We discussed these issues with the operations manager who acknowledged that the completion of behaviour support records had lapsed and behaviour support guidelines needed more information about proactive support for people.
- The provider had not ensured the principles of "Building the Right Support" were being followed as people were not always supported by using proactive strategies to reduce the risk of behaviour that challenges, in line with good practice guidelines.

This evidence indicated the provider had not developed effective behavioural support plans in line with good practice around supporting people with a behaviour that could challenge the service. This placed people at risk of not always receiving care to meet their needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw the service had been working in partnership with the local commissioning authority's positive behaviour support team to improve how the staff supported people.
- The people had been living at the service for a number of years. The provider had completed an assessment of their needs when they moved in and their care and risk management plans were regularly reviewed. The manager explained they were in the process of updating these plans using a new, more personalised format.

Staff support: induction, training, skills and experience
At our last inspection we identified people did not always receive personalised support to meet their needs due, in part, to a lack of understanding and knowledge from the staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At the last inspection we identified staff lacked awareness of people's communication needs and there was no evidence staff had received training on how to communicate effectively with people. At this inspection the provider did not demonstrate that staff had benefited from such training so as to support people in a personalised way. However, after our visit the provider supplied us with evidence that three staff out of the full complement of staff working at the service had attended communication training in the month before our visit.
● Since the last inspection staff had not always benefited from regular supervision sessions with a line-manager to discuss their performance and development. A matrix that logged supervision sessions indicated these had only taken place intermittently. Managers acknowledged these had not been taking place as regularly as required and could not provide any records of supervisions during or after our inspection visits.

We found no evidence that people had been harmed however, the provider could not demonstrate staff were sufficiently competent and skilled to meet people's needs effectively. This placed people at risk of not always receiving care to meet their needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two support staff said they had met recently with the manager and felt supported by them. One support worker said, "[The manager] is brilliant, always has an ear for you, if anything I'm worried about I can call."
● Agency staff who were working regularly at the service were not offered supervision sessions. However, one agency support worker told us they felt supported by the manager and felt they could discuss issues with them.
● One adult social care professional told us, "I think the regular carers are very good, on the ball."
● Staff training records we sampled showed some support workers had completed a variety of awareness training sessions. These covered topics such as health and safety, moving and handling, fire safety and first aid.

Adapting service, design, decoration to meet people's needs
At our last inspection the provider had not ensured equipment used by the service provider was properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● The provider had made a number of improvements to the home environment since our last inspection. These included fixing mobility and bathing equipment so people could have regular showers again, repairing doors and light fixtures and tending to the garden so people could access this again. During our visit we saw one person use the garden independently on several occasions and further maintenance repairs being completed.

● The provider had processes in place for maintaining the home environment to make sure it was safe and suitable for people. For example, there was a fault with the home's heating system during our visit and the provider quickly arranged for this to be addressed.
● People's bedrooms were clean, decorated and personalised to each individual, reflecting their likes of hobbies. People had adjustable beds and hoists in their rooms. We saw this equipment was checked regularly to make sure people and staff were safe when it was used.

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.

● People were being supported in line with the principles of the MCA.
● The provider had worked with the local authority where it had assessed people lacked the capacity to agree to their care arrangements and there was a concern restrictions could have amounted to a deprivation of their liberty.
● Where a person's deprivation of liberty had been authorised, we saw the provider made sure it had a copy of the legal authorisation for this. The provider had acted to fulfil the conditions of a person's authorised deprivation of liberty. For example, completing a mental capacity assessment and best interests decision regarding the use of bed-side rails with a person so they could use their bed safely.
● Staff training records we sampled showed some support workers had completed awareness training on the MCA and DoLS.

Supporting people to eat and drink enough to maintain a balanced diet
● Relatives said people were supported to eat and drink a varied diet of freshly cooked food. One relative said, "They feed them alright." Relatives appreciated the healthier eating initiatives staff had recently introduced. Staff told us there was always enough food to prepare meals for people.
● People's care plans described their food likes and dislikes. Records of daily care indicated people were supported to eat a variety of meals that reflected their preferences. We saw people were offered drinks throughout the day and daily records also showed this.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access healthcare services and to have their health needs met. This included supporting people to attend annual health checks, appointments with consultants, nurses, therapists, chiropodists and GPs. We observed the manager support a person to attend a health appointment during our inspection.

● People were supported to maintain their oral health, which was included in people's care plans. Staff supported people to use adapted toothbrushes to brush their teeth, where appropriate. Daily care records indicated staff supported people to maintain their oral health and attend regular visiting dentist appointments at home.

● Staff involved other healthcare professionals in people's care. They had worked with other healthcare professionals recently to consider if a dental concern may have been contributing to a person acting in a distressed manner.

● People had hospital passports that described their care and support needs and what was important to them. These documents promoted person-centred working with other healthcare agencies because they described how people communicated and what they needed support with.

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 remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated in a way that promoted their dignity or showed respect and empathy for their experiences of the care they received.
- We observed support staff serve two people their breakfast toast on pieces of kitchen roll rather than plates. When we asked staff about this they could not explain why they had done this.
- We saw staff placed an apron on one person's front and then set this in place at the kitchen table by putting the person's breakfast plate on top of it. The person's care and risk management plans did not set out that the person needed to be supported in this way. This appeared to restrict the person's freedom to move away from the table without upsetting their plate.
- The provider had also not been always caring to people because they had not always acted in a prompt way to ensure their safety. The provider had not always taken people's safety into account by making sure incidents were appropriately dealt with and that they received their medicines safely. They had also not deployed staff in adequate numbers to meet all of people's needs in a timely manner and ensured that the staff were adequately supported in their role to care for people appropriately.
- We saw some instances of staff treating people respectfully and acting in a caring manner. For example, we observed staff provide kindly, attentive and reassuring support to a person while and after they experienced a seizure. This approach was also described in the person's seizure support guidelines. We also observed staff offer personal care to a person in a discrete and polite way.
- Staff we spoke with explained how they promoted people's privacy and dignity when providing support and personal care. This included speaking with the person throughout, respecting people's choices, and making sure the environment was private and people were appropriately covered. One support worker said, "Talking to them is a big part," and described how a person preferred to be supported to wash.
- Some people's care plans gave specific guidance on promoting their dignity. For example, one person's plan stated the types of clothing they should be supported to wear in hot weather that helped them to remain comfortable but promoted their dignity.
- At the last inspection we frequently observed staff entering rooms where people were or supporting people without speaking with them. At this inspection with observed staff interacting more positively with people throughout the day.
- Relatives told us they thought staff were caring. An adult social care professional told us they had observed staff being caring towards people.
- Staff described how they supported people to do some things independently in a way that was

meaningful for them. We also saw staff encourage people in this way, such as involving a person in preparing their breakfast.

● People's care plans provided information about people's cultural and family background and their religious preferences. We saw the service had worked with one person's family to record a detailed personal history for the person. This information helped new staff get to know people.

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

● We saw that people and their families were involved in planning and reviewing their care. This gave people an opportunity to make decisions about their care and support arrangements.

● When we observed staff interact with people we saw they were patient and gave people time to make choices. For example offering a drawing activity, asking what people wanted to drink, or where they wanted to sit or move to. Staff we spoke with also described how they supported the people to make other choices, such as they clothes they preferred to wear or food for breakfast.

This indicated people were supported to make some day-to-day decisions about their care.

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 now remained the same.

This meant people's needs were not always met.

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

At our last inspection the provider did not ensure people's care and treatment was appropriate, met their needs and reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At the last inspection we found people were not supported to engage in meaningful activities, opportunities to learn or develop their skills or interests or to meet their sensory needs. At this inspection we found this continued to be the case, although some improvements had been made.
● The provider had continued to not ensure the principles of ''Building the Right Support'' were being followed as people were not always supported to have good and meaningful everyday lives.
● One person's care plan stated they did not like to be left on their own too long and enjoyed eye contact and communicating with others. However, during the inspection we observed this person experienced limited interaction with or stimulation from staff throughout the day. Staff were friendly when they engaged with the person, but this happened infrequently. For example, over a period of three and half hours staff only spoke with the person when staff moved their wheelchair, supported them to take some medicine, or helped them to eat or drink.
● We observed this person spent their day in the lounge with the television on and their wheelchair in the same place. The chair was positioned in such a way that the person could mostly only see upwards and not at the television, or others. Their care plan stated the films or musicals the person liked to listen to or watch. Staff did not speak with the person about what was on the television or change this to things the person was known to like.
● Another person spent most of their time sitting in or moving around the downstairs hallway or corridor area. Their care plan stated they sometimes liked to be on their own, but it also stated they liked to be involved in things and staff should encourage the person to help staff with whatever they were doing. While staff regularly greeted the person and asked if they wanted a drink, we only observed two occasions where one support worker tried to support the person with an activity.
● Daily records of care indicated these people's days often passed doing the same things.

● Relatives told us people did not experience sufficient meaningful activities or opportunities to get out into the community. One relative believed staff supported their family member to go out less than once a week. Care records confirmed this. Another relative said they thought some social activities had stopped happening, such as inviting other people to visit to celebrate people's birthdays. Relatives said they felt the low and inconsistent staffing levels contributing to staff not having time to support people to do things. One relative commented, "It will be ideal to have someone to do things with them, then the other two staff could do other things." A member of staff also told us the service would benefit from, "More staff on the floor."
● There was a monthly timetable of daily activities for staff to support people with when at home. However, daily records of care indicated these activities did not always happen. For three days the only planned activity listed was to support people to have lunch in the garden.
● At the time of the inspection we received information suggesting people were only supported to have bed-baths or strip-washes rather than baths or showers. The records of daily care we reviewed did not always provide a clear picture of whether people were receiving baths or showers according to their individual preferences. We asked the provider to look into these concerns and they were still investigating when this report was being written.

This evidence indicated the provider had not ensured people's care and treatment was always appropriate, met their needs and reflected their preferences as some people were not always supported to experience meaningful everyday lives. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed these concerns with the managers. They acknowledged that some people did not benefit from activities and interactions that were meaningful to them throughout the day. They hoped the new staffing arrangements they were introducing would help to improve people's experience of the time they spent at home. Managers also planned to recruit more staff who could drive the home's vehicle so they could help people to get out and about more often.
● We also observed other people enjoying positive interactions with staff. For example, staff frequently spent time with one person during the day. They helped them with activities such as drawing and playing a musical instrument, as well as playing and laughing with a variety of toys, figures and other objects.
● Another person moved around the house independently. We saw they accessed the garden patio area when they wanted to or listened to music of their choice using headphones in a corner of the lounge. Staff regularly chatted with the person throughout the day and the person appeared to enjoy this.
● Care records indicated that some people had benefited from more activities since the last inspection. For example, a pampering session, aromatherapy sessions had continued, cake-making, meals out, and trips out, such as to Windsor Castle and a zoo. One person had been supported to go on holiday. A support worker told us, "It was brilliant, [the person] laughed the whole time. I've never seen [the person] laugh so much."
● People's care and risk management plans provided personalised information about them, such as their physical, mental and social needs and their care and support preferences. For example, one person's plan set out the personal grooming products staff needed to support the person to use and the types of clothes the person was known to prefer. People's plans were regularly reviewed. However, one person's did not include up to date information about their epilepsy support. The manager was in the process of introducing a new care plan format to provide more personalised information about each person.
● The staff we spoke with were knowledgeable about people and their individual needs.

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.

At our last inspection we noted the service had not complied with the AIS and this contributed to a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made. While people's communication needs were identified and recorded in their care and risk management plans. Staff did not consistently meet these needs in practice.

● One person's care plan identified they used Makaton to communicate. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. The plan listed the signs the person used and a support worker described how they used Makaton signs with the person stating, "I'm learning from [the person]". However, we did not observe any staff using Makaton to promote communication with this person during our visits.
● The provider could not provide evidence that staff had received training to be sufficiently competent and skilled to meet people's communication needs effectively.
● The service had a pictorial board to help show people which staff were working, but this was not being used when we visited.

We found no evidence that people had been harmed however, this evidence indicated the provider had not ensured people's care and treatment was always appropriate and met their needs. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person's care plan stated they did not use words to communicate and described how they indicated they wanted something, were upset or responded 'yes' to questions. We observed staff interact with the person in line with this information.

Improving care quality in response to complaints or concerns
● There provider had appropriate complaints handling processes in place. There were no records of recent complaints.
● Relatives said they had not made any complaints, but they could raise concerns to the managers and felt they would be listened to.

End of life care and support
● No one was receiving end of life care at the time of our inspection.
● People's care plans indicated potential end of life care needs had been considered. People had been supported to develop plans for the future based on their known likes and preferences. The manager also showed us how they were working with a person's relatives to update their plans.

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 requires improvement. At this inspection this key question has now remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
At our last inspection the provider had not ensured systems and processes were operated effectively to assess, monitor and improve the quality and safety of the service, or assess,
monitor and mitigate risks to the safety and wellbeing of service users. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider's quality monitoring systems and the leadership team had not addressed concerns regarding the deployment of enough sufficiently competent and skilled staff to meet people's needs effectively. This was despite this concern having been identified at the last inspection.
● The provider's systems and governance arrangements had not identified or addressed requirements to ensure medicines were always managed in a safe way, that there were positive behaviour support plans in place for people, and that their communication needs were always met. Nor did people receive care and support that always met their needs, reflected their preferences and supported them to experience meaningful everyday lives.
● Managers conducted weekly checks of medicines records and took action to address issues these noted. However, these checks had not always been effective as they had not identified the MAR recording issues we noted.
●While there were management staff in the home and visiting senior staff, they had not monitored, assessed and improved staff's interaction and engagement with people using the service to ensure they were always cared for with respect and empathy.
● After the last inspection the provider set out in an action plan their assurances they would make improvements at the service. At this inspection we found repeated breaches of regulations. This indicated the provider had failed to make the necessary improvements required.
● These concerns indicated the provider had not ensured the principles of "Building the Right Support" were being followed as people were not always supported by enough sufficiently competent and skilled staff to meet their needs effectively and to experience good, meaningful lives.
● Relatives said management changes since our last inspection had affected leadership of the service in the

home. Relatives said they were aware of disharmony between some of the support worker team as well. Their comments included, "After [the previous registered manager] went it seemed to fall apart," and "I just want to get back to a stable situation." Staff we spoke with acknowledged there had been difficulties due to the management changes. One staff member said, "I feel like the dust has settled now."

We found systems were either not in place or robust enough to demonstrate safety and quality was effectively managed and improved. This placed people at risk of harm and not always receiving care to meet their needs. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The operational manager acknowledged there had been a lapse in the quality assurance processes at the service since the last inspection. The provider had arranged for a comprehensive review of the quality of the service at the time of our visit. This review informed a detailed action plan for improvements and we saw the provider had started to complete these actions after our inspection.
● Staff we spoke described being committed and motivated to provide people with good support.
One relative said that, despite the staffing issues, "The care is good."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There had been several management changes at the home since our last inspection. The previous registered manager and deputy manager had left and then a temporary manager had worked at the service for several months. The current manager started at the service three months before our inspection. The operations manager told us they were in the process of applying to be the registered of the home. However, the CQC had not received an application for this at the time of writing this report.
●Staff said they found the manager supportive and knowledgeable. Relatives found the manager approachable and one relative commented, "We know we can ask and tell [the manager] anything." The manager told us they felt the operations manager supported them in their role.
● The service's last performance rating was displayed at the home and on the provider's website, as required by law.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider used to hold regular meetings with relatives to discuss the service, but these had stopped happening since the previous registered manager left in February 2019. Relatives said this meant they were less involved in and received less communication about the service. Their comments included, "[We're] missing that get-together," and "There's lack of information coming through."
● We saw only one team meeting had taken place since our last inspection. This meant there had been less opportunity for staff to be involved in the running of the service. The operations manager confirmed these meetings had stopped due to the management changes and told us they would be re-started.
● The manager and operations manager were open about acknowledging some of the issues we found at this inspection. They had identified some of these and were in the process of establishing new ways of working to address these. For example, addressing the staffing and recruitment issues and improving people's day to day opportunities to go out and experience meaningful activities.
● Relatives told us that when something had gone wrong the provider explained what had happened and had apologised to them. For example, when there was a mistake supporting someone to take their prescribed medicines.
● The provider had not conducted any annual stakeholder or feedback surveys since our last inspection.

The operations manager said these were due to start shortly after our inspection.

Working in partnership with others

● The provider had been working in partnership with relatives and adult social care professionals when providing care to people. One professional said the staff were receptive to their advice and would contact them if they had any concerns about a person.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users because they did not always: : Assess the risks to the health and safety of service users receiving care : Do all that was reasonably practicable to mitigate such risks : Ensure the safe and proper management of medicines 12(1)(2)(a),(b),(g)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that service users care and treatment which was appropriate, met their needs or reflected their preferences. 9(1)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not always operating effective systems and processes to: - Assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity. - Assess, monitor and mitigate the risks relating to the health safety and welfare of service users. 17(1) and (2)(a),(b)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the needs of service users.18(1)

The enforcement action we took:

Warning Notice