Lifetime Care Development Limited

The Grange

Inspection report

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Herne Bay
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Tel: 01227741357

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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

This inspection took place on 23 March 2018 and was unannounced.

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

The Grange is a small care home for people with learning disabilities, some of whom displayed behaviours which may challenge others. The service is in the village of Beltinge, a short distance from Herne Bay. There is a communal lounge and kitchen downstairs and bedrooms are situated throughout the premises. At the time of this inspection there were five people living at the service. Some people were more independent than others and able to make their own decisions, whilst others needed support and assistance from staff to remain as independent as possible.

There was a registered manager in post, they were also the registered provider and owned the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be supported to live as ordinary a life as any citizen.

At our last inspection we found that guidance for staff was lacking and people's care plans had not been updated to include information about their health care needs or when the support they needed to manage their behaviour changed. Activities were repetitive and people spent most of their time 'watching tv' 'listening to music' and 'going out for a drive.' There were no plans in place to increase people's independence. We recommended that the provider trained staff in areas of best practice relating to supporting people with learning disabilities, including person centred planning, person centred active support and positive behaviour support. We found three breaches of the regulations regarding safe care and treatment, person-centred care and good governance.

At this inspection we found ongoing concerns. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Although senior staff had re-written people's care plans, staff and the registered manager lacked knowledge and understanding regarding best practice when supporting people with learning disabilities. Staff had not received the training we recommended at our last inspection and people were not supported to be as independent as possible. Activities remained ad hoc

and unplanned, and continued to be repetitive. There were no systematic plans in place to assist people to learn new skills or experience new things. Staff had not discussed with each person what they wanted to happen at the end of their lives.

Sometimes people displayed behaviour that challenged. These behaviours could result in both verbal and physical aggression towards staff and other people living at the service. Staff documented these incidents in people's daily notes, but did not consistently complete incident forms or handover when these incidents occurred. We found instances of potential abuse documented in people's daily notes that had not been reported to the registered manager or the local safeguarding team. After the inspection the registered manager emailed us to tell us they believed these incidents related to, 'wording' and were 'not incidents.' They had not consulted with the local safeguarding team to see if they felt these were incidents of abuse. No analysis was completed of accidents or incidents to look for trends and patterns or ways of reducing the chance of an incident occurring again.

Risks relating to people's care and support had been identified, however they were not fully assessed and guidance for staff was lacking in places. The service was dirty in places and some areas smelt of urine. Some areas of the service had been adapted.

Staff did not always refer to people in a respectful manner. They had documented that people were 'rude' and 'sulking' when they displayed behaviour that challenged.

At our last inspection people had not been involved in planning their meals or shopping for ingredients. We identified this as an area for improvement. At this inspection, we found the same situation. We recommended the provider sought advice on involving people in aspects of their care. Information was not presented to people in an accessible format, which limited their involvement in planning their care. The registered manager had not considered alternative ways of seeking people's feedback on the service in order to make improvements.

The registered manager told us that people's relatives and other stakeholders had been asked their views on the service. However, they were unable to provide evidence of this during the inspection. Responses had not been collated or analysed to look for ways of improving the service.

The registered manager had applied for Deprivation of Liberty Safeguards (DoLS) when people did not have capacity to consent to staying at the service. However, they had failed to notify the Commission as required. Services that provide health and social care to people are required to inform CQC of important events that happen in the service.

The registered manager lacked oversight of the service. The provider's recruitment policy had not consistently been followed. Some checks and audits were completed but they had failed to identify the issues that we highlighted at this inspection and had failed to implement improvements following concerns raised at our February 2017 inspection.

There were enough staff to keep people safe, and staff were present throughout the inspection. Medicines were managed safely and people received them as and when needed. People were supported to see health care professionals when their health needs changed. The registered manager told us there had been no complaints since our last inspection.

Some people attended day services and staff worked across organisations and liaised with staff there to provide a joined up approach. The registered manager had worked in partnership with professionals from

the local authority regarding people's care and support.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The registered manager had not consulted with the local safeguarding team when potential instances of abuse had occurred.

Risks were identified but not always assessed or mitigated fully.

Accidents and incidents were not analysed to look at ways of reducing the chances of them occurring again.

The environment was not always clean and areas of the service smelt unpleasant.

The provider's recruitment policy had not consistently been followed. There were enough staff to keep people safe.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received training in areas of best practice when supporting people with learning disabilities.

People's care plans had been re-written since our last inspection, but people's needs had not been assessed in line with best practice.

The registered manager had applied for Deprivation of Liberty Safeguards (DoLS) when people were unable to consent to living at the service. Staff understood the principles of the Mental Capacity Act (2005).

People were not supported to plan their meals.

People received support to manage their healthcare needs. Referrals had been made to relevant healthcare professionals when needed.

Some adaptions had been made to the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Information was not always accessible to people, limiting their input into planning their care and support.

Staff were not always respectful to people.

We observed some kind and caring interactions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities were adhoc and there were no plans in place to increase people's independence or support them to learn new skills.

Staff had not consistently discussed with people and their relatives what they wanted to happen at the end of their lives.

There had been no complaints since our last inspection.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was not meeting all of their regulatory responsibilities and had not ensured compliance with all of the fundamental standards and regulations.

The provider lacked oversight and checks and audits had failed to identify the issues we found at this inspection.

Feedback about the service was not always acted on to drive improvement.

The provider did not have a clear strategy for the service.

The service had worked in partnership with other organisations such as the local authority commissioning team.

The Grange

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 site visit took place on 23 March 2018 and was unannounced. The inspection was carried out by two inspectors.

We used information the provider sent us in the 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 looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

Before the inspection we spoke to one person's care manager in the local authority.

We spoke with the registered manager, the deputy manager and three members of care staff. We looked at three people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

During the inspection we spent time with and spoke with the people living at the service. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. 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.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection there was a lack of guidance for staff regarding how to support people who displayed behaviour that staff found challenging. At this inspection we found the guidance for staff had improved, however there were still concerns regarding the action staff took when people displayed behaviour that challenged.

We found multiple references in people's daily notes to them displaying behaviour that challenged. For example, on 31 January 2018 staff had written, 'After breakfast [person] decided to punch [another person] for no reason. They then spent the next few hours screaming, shouting and attacking staff for trying to discourage their violent behaviour.' On 28 January 2018 staff had written that a person was, 'very rude to staff' 'stormed off to their room whilst shouting and swearing' and 'sulked in their room.' On 27 January 2018 staff had written, '[Person] decided to ram [another person] with their frame. Staff then spent the next hour trying to explain to [person] why this is not acceptable behaviour.'

We spoke with the registered manager about these incidents where it appeared people had may have been hurt. They had not been aware that these incidents had occurred. The registered manager emailed us after the inspection once they had spoken with staff and stated, 'It is obvious to me that it is the wording and not an incident, which of course would explain why I have not seen the incident reports because in fact there was no incident so no report was completed.' They had failed to acknowledge the potential harm which may have been caused to people and had not discussed the incidents with the local safeguarding team. Although incidents involving both verbal and physical aggression towards staff and people were regularly occurring the registered manager and senior staff had no oversight of these. Staff did not consistently record incidents separately, and no analysis was completed of incidents that occurred to look for potential triggers or ways of reducing the risk from occurring. There was a lack of understanding regarding best practice when supporting people with behaviour that challenged, staff did not recognise that people's behaviour could be a form of communication and required support to manage their behaviour positively.

The provider had failed to ensure that people were protected from instances of potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were identified and assessed. However, there was no assessment of the likelihood of the risk happening and the severity to the person if the risk occurred. This made it difficult to prioritise risks to people and to establish what control measures were needed. Some assessments lacked detailed information that staff might need if a risk occurred. For example, when a person was at risk of choking the risk assessment in the care plan stated that if the person choked 'deal with them appropriately.' No further information was provided in the care plan about what 'deal with them appropriately' meant. The provider pointed out that there was a printed flow chart in the care plan showing generic action a person should take if a person choked. This was not individualised to the person's needs, however.

Another person had been assessed by a Speech and language therapist (SaLT) as needing a 'soft moist diet' to reduce the risk of them choking. There was no information for staff in the person's care plan about what

foods constituted a soft moist diet. At lunchtime we observed the person was given and ate a beef burger and chips. These were cut into small pieces and served with ketchup. At tea time they were given and ate a cold Cornish pasty. The provider told us they thought that the food served was in line with a soft moist diet. We asked the provider to check with the SaLT that these foods constituted a soft, moist diet to reduce the risk of the person choking. The lack of clarity on what consistency of food was required for this person placed them at risk of choking.

Staff had attended training in fire awareness and knew what to do in the event of a fire. Each person had a personal emergency evacuation plan (PEEP) but one we looked at required more detail about the support they needed in an emergency situation. For example, there was no photograph of the person or information about what support they might need to evacuate. PEEPs were kept in care plan files and we suggested copies be placed in a 'grab file' by an exit in case the information was needed in a hurry. The deputy manager said they planned to create a grab file. Regular practice drills were held so people practised leaving the building and fire equipment was tested and checked regularly.

At our last inspection there was no environmental risk assessment in place. At this inspection an external company had carried out an environmental risk assessment in March 2018 with no actions needed. However, we noted environmental hazards including a broken radiator cover, which increased the risk of people being burned in the lounge and an unpleasant smell in one bedroom that had not been identified in the assessment. The provider had carried out monthly checks and ticked a sheet which included 'any odour problems' and 'décor.' These areas had been ticked for the past few months showing no issues when in fact, action was needed.

The provider had failed to ensure that risks were adequately assessed and action was taken to mitigate them when possible. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no cleaning staff employed so care staff carried out cleaning tasks. Some parts of the service were not as clean as they could be and one part did not smell fresh. The bathroom and sink in one bathroom did not look clean; the carpet in the lounge under dining tables appeared to have bits of food on. The carpet was vacuumed later in the afternoon. One area of the service did not smell very pleasant and smelt of urine. The provider said they had installed air fresheners and the deputy manager said they had mopped the floor that morning however; there remained a strong smell which needed addressing.

We recommend the provider seeks advice from a reputable source regarding ensuring the service remains clean and smells pleasant.

The provider's recruitment procedures were not fully followed. One staff member lacked a recorded full employment history from 2013 to 2016 and two staff had Disclosure and Barring (DBS) checks completed by another organisation rather than by the provider when they started work at the service. These two DBS checks were two and three years old with no further criminal background check completed since that time.

There was enough staff to meet people's needs. The provider did not use any tool based on people's needs to work out the staffing levels needed. They based staffing on their knowledge of people and what activities or appointments were planned. The deputy manager explained that although they spent time in the office they would step in to cover any staff shortfalls. On the day of the inspection a staff member had called in sick and the deputy manager was working alongside staff to cover this shortfall. Later in the day an additional staff member came in to support the staff team. Some people went out on their own and others had one to one support from staff. People said that staff were around when they needed them. We observed that staff

were present in communal areas and on hand when they were needed.

Staff had a good understanding of people's medicines, what they were for and what side effects to look out for. Medicines were stored safely and administered by staff who had been trained. People told us that this system suited them. Staff made sure that medicines were stored at the correct temperature. Medicine records were up to date and correctly completed, staff told us they checked the records each day and followed up on any errors but said that errors were rare.

Some people took medicine that they needed only now and again, for example pain relief. There was a lack of guidance about when to give these medicines, the time needed between doses and the maximum dose allowed in 24 hours. Although staff knew people well and told us about signs that people used to say they needed their PRN medicine, it would also be beneficial to have a written record of when and how much PRN medicine should be given.

Some people needed to use creams to help keep their skin healthy. There were no body maps to remind staff where to apply the creams. The deputy manager agreed to address these issues.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in February 2017 we recommended that staff received training related to people's needs, including: person centred planning (PCP), positive behaviour support and person centred active support. This recommendation was made to encourage the provider to give staff training in subjects recognised as best practice in supporting people with learning disabilities. PCP is an empowering approach to help people achieve their goals and live the life they want. It helps people plan for the future and organise the systems and support they need to lead a life that 'makes sense to them.'

PCP is designed deliberately to shift power towards the individual and encourage maximum involvement in planning and decision-making. PCP seeks to extend the range of options and choices, promoting independence and encourages people to take charge of their own lives. To support PCP staff need to have effective training and support.

Since our last inspection some staff had attended a three hour course on learning disabilities but training in the subjects regarding person-centred planning and positive behaviour support had not been arranged. Staff continued to lack understanding about PCP and could not tell us what active support or positive behaviour support was. Staff continued to do things for people rather than use active support techniques to do things with people. People were not empowered to get involved in the day to running of the home. For example, we observed that staff cooked and served the meals and cleaned rather than supporting people to be involved.

Staff and the registered manager lacked an understanding regarding best practice when supporting people with learning disabilities. People had care plans in place, and their needs had been assessed, however this was not in line with best practice guidance. There was no systematic plan in place to increase people's skills or encourage their independence.

The induction for new staff was basic and included a five page checklist with ticks and dates which did not show how the staff member was assessed as being competent. The induction was not based on the Care Certificate which is an identified set of nationally recognised standards that social care workers should adhere to in their daily working life.

Staff had the opportunity to meet with a line manager for a supervision meeting on a regular basis to discuss any issues and training needs. Not all staff had a yearly appraisal, the deputy manager agreed that appraisals had been 'hit and miss' and said they were trying to arrange appraisals on a more regular basis.

The provider had failed to ensure that staff were suitably qualified, competent and skilled to carry out their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we identified that there was little involvement by people when planning menus. The registered manager ordered the shopping on line and then people choose from the food available. People

were not involved in going to the supermarket to choose the food and there were no formal records to say if they had been involved in planning the menu. We described this as 'an area for improvement.' At this inspection we found a similar situation. Although people regularly went shopping, there was a lack of formal involvement in the planning of menus. We asked people at the start of the day what was for lunch, and were told, "I do not know." People were asked what they wanted to eat from the food available, but had not participated in choosing it. There was a rolling menu displayed in the kitchen, but this was not in a format accessible to people. No pictures were used to reinforce what different types of food on offer, and people had not been involved in planning the menu itself.

We recommend that the provider seeks advice from a reputable source regarding involving people in planning and preparing meals.

We observed the lunch time meal and staff sat separately to people. The deputy manager told us that staff usually ate with people, however, had chosen not to that day. Staff chatted to people and there was a calm atmosphere. There was a staff member on hand to offer people assistance if necessary.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Some people were unable to consent to living at the service and the registered manager had applied for DoLS when necessary. Some of these had been authorised by the local authority and people were visited regularly by an advocate. However, the registered manager had failed to notify us that these had been authorised, as required by law.

Staff had an understanding of the MCA and offered people choices during the day. People's capacity to make decisions about their care had been assessed. People were asked what they would like to drink and if they wanted to listen to music or watch television. One person chose to go out independently and staff respected their decision.

Staff had sought advice from a range of healthcare professionals, including psychologists, to assist people to live healthier lives. People were supported to see a doctor when they were unwell and attended regular health screenings. One person told us, "They check my tablets at the doctors and last time I went, the doctor asked me how I was." Since moving to the service one person had lost weight, as they were supported to be more active.

People told us they were happy with their bedrooms and two people showed us their rooms. Each bedroom was a single room with a wash hand basin. Toilets and bathrooms were shared. Bedrooms were personalised with people's own pictures and belongings. There were hand rails in some bathrooms to assist people a shower seat was provided for one person. There was a small garden to the rear of the house accessed through the kitchen.

Requires Improvement

Is the service caring?

Our findings

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. The provider told us that people's preferred communication methods were verbal. However, people were not fully involved in writing and developing their care plans. The deputy manager had re written some care plans without people's involvement. Care plans were not accessible to people or produced in a way that was meaningful to them such as using pictures or in an easy to understand format.

The service had not been designed to support communication. For example, the menu was written in small print and displayed high up on a notice board in the kitchen. Some people could not see it, to know what was on the menu from day to day. People were not aware of who would be supporting them and what activities were on offer as this information was not provided to them. Without accessible information people could not make informed choices.

Staff spoke with people in a calm and patient way although at times people were not always treated with respect. For example, we asked the deputy manager if the kitchen was accessible to everyone and they replied, "Yes, we don't have any runners anymore" which was not a respectful way of describing people who might want to leave the service. Staff did not always refer to people in a respectful manner. Staff had written that one person was 'known to be violent and crafty.' Staff had written in one person's daily notes that they had been, 'very rude' 'stormed off' and 'sulked in their room.' No consideration had been given to how people may feel to be described in such a way and demonstrated a lack of understanding about how people's behaviours may be a communication of their needs.

There were no plans to increase and develop people's independence or skills. For example, there were no plans to support people to have more control of their money or medicines and no plans to teach people life skills like cooking, how to do the laundry or budgeting. This was not in line with the principles of 'Building the Right Support' which is a national plan to develop services for people with a learning disability and/or Autism.

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

We observed some kind and caring interactions between people and staff. People appeared relaxed in the service, and spent time chatting and laughing with staff. Most staff had worked at the service a long time, and knew the people living there well. People's privacy was respected and staff knocked on people's doors before entering.

Staff supported people to keep in touch with their family and friends supporting them to phone and/or visit.

People could have visitors when they wanted to. People's personal confidential information was stored securely.

Some people had family members to support them and others had advocates to help them air their views. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection activities were not planned in advance and there was no way of prompting or encouraging people to try new things. There were no goals or aspiration plans in place to ensure that people had a meaningful activity programme. There was no information in people's care plans to show that any goals had been discussed with people. There were no activities linked to developing learning, and exploring new activities or challenges.

Staff had now met with people and goals had been recorded. These included, attending a day centre for another day a week and ensuring all medicines were administered on time. However, there were no plans in place to show how goals were to be achieved. People's care plans made multiple references to people being supported to, 'achieve their full potential' however, there was no systematic plan in place regarding how this should be achieved. Best practice when supporting people with learning disabilities includes the fact that people should be encouraged to be as independent as possible, and plan ways in which they could achieve this. People were not involved in household tasks such as cleaning or completing their laundry. One person told us, "They have stopped me going in the laundry room."

During this inspection people spent time at the service watching TV and listening to music. One person went without staff for a walk and other people were supported to go to the shops with staff. One person was engaged in a game of snake and ladders with staff and another helped to make a bread and butter pudding for people to eat later in the day.

Although people appeared content with how they spent their time, activities remained adhoc and the deputy manager told us, "They [people] are very set in their ways." People's daily notes continued to show people spending a lot of time, going for 'a drive out', 'listening to music' and 'watching TV.' We were told by multiple members of staff that people were 'food orientated' and activities had to include this. No consideration had been given to offering and encouraging people to try or learn new things or incorporating food into different activities to increase people's experiences.

The deputy manager told us that a trip to a theme park was in the process of being arranged. People had enjoyed a trip to a sea side holiday park in the Summer holidays.

Staff had not consistently discussed with people and their loved ones about what they wanted to happen at the end of their lives. Some people had funeral plans in place and these had already been paid for. Staff had not discussed if people would like to remain at the service or what they would like to happen at the end of their lives, such as specific music playing or people present. Senior staff told us that some people's relatives may find it difficult to discuss these plans. However, people and their loved ones were getting older, and it was important to have a detailed record of people's wishes.

The provider had failed to ensure that care was planned and delivered in line with people's preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection people's care plans did not clearly detail their medical conditions and lacked guidance with regards to their behaviour. The plans had not been consistently updated when people's behaviour had changed. At this inspection people's care plans had been reviewed and re-written. Staff had met with people to discuss their care and support. Information regarding people's health care needs and basic information regarding their care and support was now accurate. People's preferences, including how they liked to be supported had been documented in their care plan. However, there were still areas where guidance for staff regarding risk management, such as the ways to reduce the risk of a person choking were still not always clear.

The provider's complaints procedure was displayed on a notice board in the hallway. There was a written policy and a separate three page policy with pictures included to make it more accessible. The provider told us that there had been no complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. At our last inspection we identified breaches of the fundamental standards and regulations regarding safe care and treatment, person centred care and good governance. At this inspection we found these breaches continued. The provider had not ensured compliance with regulations and we found new concerns relating to the competency of staff and reporting of potential safeguarding incidents.

The registered manager had led the service for many years and was also the provider. They had not kept their knowledge and understanding regarding best practice, or the changes in fundamental standards and regulations up to date. The registered manager told us they had recently tried to attend a forum with other managers in the local area, but there had been a confusion regarding dates. Since our last inspection they had not attended any other events to share best practice or update their knowledge. The way the service operated was not in keeping with the principles of 'Building the Right Support,' a national framework for developing services for people with a learning disability and/or Autism. This includes encouraging inclusive activities to enable people to have meaningful lives, encouraging people's involvement and choices and ensuring care is person-centred and proactive. This was not recognised by the registered manager and therefore the service had not been developed in line with this.

We asked the provider about their strategy for the service and they were unclear that they could or should have one. We explained that it was part of our methodology to report on the vision, strategy and culture of the service and they then told us they wanted to, "seek people's views." We expect providers to seek and act on people's views to continually improve the service as a matter of course. The provider said they sent out satisfaction surveys to relatives and advocates and they, "rarely get a response from care managers." The provider was only able to find one survey dated September 2017 from a care manager which stated '(Person) would benefit from some, one to one interaction in the community.' There was no action plan to take this suggestion forward and the person was not regularly accessing the community on a one to one basis.

People and staff were not formally asked their views on the service. The provider said they talked to people and staff at meetings but people's views were not recorded, nor was their feedback on the service. We asked about how else people's views were sought to help shape and improve the service to which the provider said "It's very hard, you would get no sense from (some people). We used pictures once it didn't work." The provider had not considered how they might support people to be involved to give their views about improving the service. The provider could not give us an example, when we asked of a change or improvement made based on people's views.

At our previous inspection, the provider's checks and audits had not picked up the issues we found including shortfalls in medicine records, risk assessments, staff competency and care planning. There continued to be no recorded checks of daily records to ensure these remained accurate and up to date. We found a number of incidents, including potentially abusive incidents, recorded in daily records that the provider said they were unaware of. This lack of governance and oversight placed people at risk as incidents were going unchecked with no debrief or review of people's support to ensure their needs were being met.

There was no oversight of incidents or accidents so the provider was unable to tell us if incidents were increasing or decreasing or where and when they were likely to happen.

The provider had failed to establish and operate systems 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.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The provider had not notified the CQC of the outcome of Deprivation of Liberty Safeguards authorisations, as required.

The provider had failed to notify CQC of notifiable events in a timely manner. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People had lived at the service for some time and appeared relaxed in the company of staff. Staff cared for the people they supported, however, due to a lack of understanding regarding best practice when supporting people with learning disabilities there was an outdated culture and people's experiences outside of the service were limited. People were not supported to be as independent as possible, and there were no plans in place to assist people to learn new skills or experience new things.

The registered manager had worked in partnership with the local commissioning team and people's care managers. Care managers are social care professionals who are responsible for overseeing people's care packages. Some people attended regular day services, and staff liaised with the staff there to ensure a joined up approach.

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. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall. The provider currently had no website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of notifiable events in a timely manner.

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 care was planned and delivered in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks were adequately assessed and action was taken to mitigate them when possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were protected from instances of potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The provider had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were suitably qualified, competent and skilled to carry out their roles.