Nash Care Homes Ltd

Ashleigh House

Inspection report

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14 March 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Ashleigh House is a large detached house. It is registered for the support of up to nine people with physical and learning disabilities including autism. Eight people were using the service at the time of our inspection. The service is larger than current best practice guidance. The service comprised of five ground floor bedrooms, three of which had on-suite facilities. There were four further bedrooms on the first floor, three bedrooms had en-suite facilities. Two communal bathrooms were also on the first floor although one of these was not in use at the time of our inspection. People were able to use two lounge areas and a dining room. There was a small outside space with a lawn area and seating.

People's experience of using this service:
The outcomes for people did not always reflect the principles and values of Registering the Right Support for the following reasons. Most people at the service were non-verbal and poor staff communication methods meant that people did not always have a say in how their care and support was received. People had limited choice and control about their everyday lives.

Some risks people faced were not always identified or acted upon. We found environmental risks that could impact on people's safety. Sometimes the way the service was designed had a negative impact on people. For example, the positioning of bathrooms and toilets. The provider was undertaking building and maintenance work at the time of our inspection to help make things better for people.

Staff did not always understand or remember the training they had received. Some additional training that may have helped staff meet the needs of people had not been provided. This meant there was a risk that people may not receive the care that was right for them.

Staff told us they felt supported and had regular meetings with the provider to discuss problems or issues. However, some of the recruitment practices for staff were poor and there was a risk that unsuitable staff could be employed to support people.

We were concerned that people were not able to agree to the care they received and the provider's systems meant that people were being deprived of their freedom unlawfully.

We observed people were relaxed in the company of staff and the staff we spoke with knew people well. However, sometimes people did not receive the privacy and dignity they should have.

People had enough food and drink to keep them healthy but they were not able to choose their weekly menu. Instead staff would offer alternatives if people refused the menu choice.

People were not always helped to communicate their needs or be involved in how the service was run. Although guidance had been given to staff about ways to communicate, this was not always followed.

Information was not always available to people in a format they could understand.

The provider made regular checks to make sure the service was running well. However, they did not identify the issues we found during our inspection. So, they need to do more work to make sure improvements are made.

Rating at last inspection:
The overall rating at the last inspection was good. Well led was rated as requires improvement. The last inspection report was published on 19 February 2018.

Why we inspected:
This inspection was brought forward due to information of risk or concern. Following an incident, we received information from the local authority regarding concerns about the service. We completed this inspection based on these concerns. At the time of the inspection, we were aware of incidents being investigated by another agency.

Enforcement:
The service met the characteristics of Inadequate in three key questions of safe, effective and well led and Requires Improvement in caring and responsive. We are considering enforcement action and will report on this when it is completed.

Follow up:
We will continue to monitor the service closely and discuss ongoing concerns with the local authority. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Ashleigh House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by a notification of an incident following which a person using the service died. This incident may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management and of risk, staff skills and experience and emergency procedures. We looked at these issues as part of our comprehensive inspection.

Inspection team:
Two inspectors attended on 13 March 2019 and one inspector attended on 14 March 2019.

Service and service type:
Ashleigh House is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection:
The first day of the inspection was unannounced. The provider was told we would be returning on the second day.

What we did:

Before the inspection we reviewed the information, we held about the service. This included the statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority and their safeguarding team to gain their views.

During the inspection, we spoke with people who used the service. Most people who used the service were not able to speak to us about their care experiences, so we observed how the staff interacted with people in communal areas. We spoke with the registered manager who was also the provider, the deputy manager and four staff members. We also spoke with a visiting professional and a visiting activities coordinator. We looked at three people's care records, five staff files as well as a range of other records about people's care, staff training and how the service was managed. These included accident and incident records, medicine records, daily notes and quality assurance records.

After the inspection we spoke with four family members of people who used the service and the provider sent us some additional information such as the statement of purpose, key worker information and staff meetings.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• Risks to people were not always identified or recorded and safety concerns were not addressed or acted on in a timely way to keep people safe.
• Staff were able to explain to us about some of the risks some people faced and gave us details of how they would reduce risk to people. For example, one person was at risk from sharp objects so risk assessments were in place and kitchen sharps were locked away when not in use.
• Risk assessments were in place for people, these gave a basic outline of risk with some guidance for staff to follow. However, some risks had not been identified. For example, one person had recently been taken to hospital for breathing difficulties. Records indicated this may have been due to an allergy. There were no risk assessments in place to address this issue. Where people were at risk of having a seizure, there were no risk assessments in place or guidance for staff to follow. One staff member we spoke with was not aware of anyone at risk from seizures in the service. When we spoke to the provider they told us those people at risk had not suffered a seizure for a while. However, we were still concerned that because these risks had not been recorded, staff may not know how to manage people's risk safely.
• When people's behaviour challenged the service, staff did not record the event in sufficient detail. This meant the provider could not monitor situations or seek to understand what made people anxious or distressed.
• Two people's care records contained guidance for staff to hold people when they became distressed or their behaviour challenged the service. This meant staff may restrain people in certain instances. We needed to be sure staff had the necessary skills and knowledge to do this and that if restraint was used this was with authority to do so. From the four training records we viewed only one staff member had received training in 'managing aggression' in April 2018. This type of training can provide staff with the skills they need to manage aggression in a safe way while still complying with the law. After the inspection the provider confirmed five staff including the registered and deputy manager had received this training.
• At the time of our inspection, the provider was unable to provide information about peoples DoLS (Deprivation of Liberty Safeguards) authorisations. After the inspection we received confirmation that two people had authorisations in place from January and February 2019. DoLS provides the legal authority to deprive a person of their liberty in certain circumstances. We were concerned that staff may use restraint without the knowledge and skills to do so and that people were deprived of their liberty without the legal authority to do so.
• People were at risk of harm from the environment they lived in. One person's bedroom and en-suite bathroom was damaged in several areas with broken tiles with sharp edges. This meant the person was at risk of injury from sharp edges and objects. The person's bedroom door was badly damaged with holes. Their bed was broken with protruding areas that could cause harm. The provider showed us a schedule of works in place that included the refurbishment of this person's room and en-suite.
• The first-floor communal bathroom did not have a window restrictor in place and another person's

bedroom had an ill-fitting window restrictor that would not hold under force. This meant people may be at risk of falling from height.
• Fire safety regulations were not always followed. The fire door to the lounge was wedged open with a wooden block. Two doors were missing sections of the internal strips that would give added protection in the event of a fire.
• The provider and deputy manager referred to people's rooms by their numbers but there was no signage or numbers in place. When we looked at people's personal evacuation plans, to be used in the event of a fire, we found one person had the wrong room number recorded. The lack of room numbers and incorrect paperwork meant, in the event of a fire, the emergency services may find it hard to locate people
• People were not always protected from the use of strong chemicals. We noted most cleaning chemicals for the service were stored and locked in the laundry room. However, we found cleaning fluids were accessible to people in the kitchen, under the sink. Staff told us people had access to the kitchen and the door was not locked. When we spoke to the provider about this they explained this was a mistake and they would ask staff to lock the products away.

Preventing and controlling infection
• Although the communal areas of the service were mostly clean and cleaning schedules were in place we were concerned with issues found in people's bedrooms . We were concerned that people's rooms had not been cleaned properly or could not be cleaned because of damage to fixtures and fittings. The provider confirmed, during the inspection, that damage to fixtures and fittings would be addressed as part of their ongoing refurbishment work.
•Two people had rips in their bed mattresses which increased the risk of infection control issues. There was faeces on one person's bathroom wall. The tiles and grout in one person's en-suite were badly damaged so it was hard to see how staff could clean appropriately. The same person's toilet could only be flushed by using a pen or similar sharp object inserted in a small hole to operate the flush system. This meant that people were not adequately protected from the risk and spread of infection.
• We were concerned about the lack of communal toilet and hand washing facilities on the ground floor. Staff told us the laundry room had a sink that was used for people to wash their hands before meals. After the inspection the provider told us people and staff were also able to use the sink in the kitchen for hand washing.
• The provider explained in detail their plans for creating a communal shower and toilet on the ground floor, however, this was not in place at the time of our inspection.

These concerns amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People were not always protected from safe staff recruitment. The provider had not always carried out required recruitment checks. For example, staff were asked for a full employment history but there were no written explanations for gaps in employment. This check gives the provider assurance staff members are who they say they are.
• The provider had completed satisfactory criminal record checks for staff. However, when staff had a previous criminal record there was no risk assessment in place to consider if the member of staff was appropriate or safe to work with people at the service.
• Staff told us they had received regular one to one supervision and annual appraisals. Records we checked confirmed this had happened.
• There was enough staff on duty to meet people's needs. The provider explained staffing was flexible to cover people's activities and healthcare appointments and records confirmed this. The deputy manager explained night staff had recently increased from one to two waking staff. When we looked at the rotas for

the previous four weeks we established the week of our inspection was the first week of this new process. We spoke to the provider about the importance of having two waking night staff on shift because the layout of the service would make it difficult for one staff member to hear people when they woke up or called for support.

The issues above were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People appeared happy and comfortable with staff. Relatives told us their family members liked living at the service and felt they were safe. Despite these views we found that people were not adequately protected from the risk of abuse.
• Staff did not always understand what safeguarding was and how best to protect people. Two members of staff could explain what abuse was and how to protect people, this included reporting concerns to the registered manager. However, two other staff members had little knowledge of safeguarding or what to do if they had concerns.
• We looked at staff training. The provider told us e-learning training for vulnerable adults was provided within 3 months of staff starting work and refresher training was every other year. However, when we looked at one person's training records no training had been provided in this area. We were concerned because staff may not recognise the signs of abuse or know what to do if they thought a person may be abused. This included reporting concerns to the Local Authority and the police if necessary.

The issues above were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were safely and appropriately stored. Regular stock checks were carried out to ensure people had access to their medicines when needed. The Medicine Administration Records (MARs) we looked at were completed without errors. Yearly pharmacy audits were carried out to ensure the service was complying with best practice.

Learning lessons when things go wrong
• Accidents and incidents were recorded with details of the event and in some instances the action taken afterwards, this included monitoring people after incidents occurred to ensure they were safe. However, there was very little information about how the service monitored for trends or patterns or learnt lessons following incidents. This included the action taken to reduce further risk. For example, one person had been taken to hospital because they had difficulty breathing, information suggested they may have and allergy to fish, when we looked at care records there were no risk assessment in place for allergies and care records had not been updated to consider this risk. After the inspection the provider sent us a risk assessment in relation to this incident.

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience

• Staff told us they thought they had enough skills and knowledge to help them do their jobs. However, when we spoke to staff we were concerned about their knowledge and competence in certain areas. For example, one staff member apologised to us about their lack of English language skills and was unable to tell us anything about their training in safeguarding, the mental capacity act or infection control. Another staff member lacked knowledge around the metal capacity act and safeguarding. The lack of staff knowledge in these areas meant people may not receive the care and support they needed.

• The provider confirmed they employed staff that were new to care. The one-day induction program did not give staff any training but informed staff about the environment and working procedures. The provider told us staff were expected to complete their mandatory training in a period of 3 to 6 months of starting at the service. We were concerned staff were able to work without having the necessary skills and knowledge to support people safely and effectively. The provider told us the care certificate was in place for staff induction (the care certificate is an identified set of 15 standards and outlines what health and social care workers should know and be able to deliver in their daily jobs). They told us they would start to introduce this as part of the induction but at the time of our inspection staff had not received training in the care standards.

• Staff received basic mandatory training. This included subjects such as food hygiene, fire training, protecting vulnerable adults, health and safety, infection control and the mental capacity act. Training was refreshed between one and three years. Staff were given an assessment booklet to complete at home and the provider told us they went over this with staff to check their understanding before it was sent to the training provider to be marked. However, these checks were not always effective as they had not identified staff lack of understanding in the subject areas. Some additional training had been provided for some staff such as medication training and equality and inclusion but not all staff had received this.

• During our inspection we did not see a central training record. The provider told us they were able to make sure staff had completed their training through regular supervision. The records we saw confirmed most staff had received mandatory training. However, we did see gaps, for example, one person had not received training in vulnerable adults. This meant there was a risk some staff may not receive the training they required when they needed it and therefore not have up to date knowledge on how to best support people. After the inspection the provider sent us a training matrix showing staff training for the last 3 years. We were assured to see the staff identified above had now received their training in vulnerable adults.

• People's needs were complex, and we were concerned the mandatory training provided did not cover the essential knowledge and skills required to meet people's needs. For example, staff did not receive training in relation to learning disabilities, communication needs and behaviour that challenges. From records we saw only one staff member had received training in epilepsy awareness and two staff in medicines. No training had been provided in Makaton (a type of sign language) although at least two people using the service were

noted as using this as a communication method. We did not have assurance that staff had the necessary skills and knowledge they needed to keep people safe. After the inspection the registered manager provided evidence of their Makaton training completed in April 2016. They confirmed staff were able to use some basic Makaton signs.

The issues above were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The provider told us most people at the service lacked the capacity to make decisions about their care. People had MCA assessments in place, but these were not detailed, and evidence of best interest decisions were unclear as to why the meeting was needed and what decision had been made.
• Where MCA assessments had taken place, they needed reviewing. For example, one person's MCA assessment had taken place in October 2017 and their ability to make decisions may have changed. .
• The provider told us DoLS applications had been made for people living at the service. We found some applications had been made in 2015 but the service had not followed these up with the local authority concerned so we were unable to confirm why there had been a delay in authorisations being considered.
• One person had a DoLS authorisation in place from January 2018 for six months. Recommendations had been made on the authorisation around the need to improve record keeping but we could see no evidence of this being done. The authorisation expired in July 2018, but the provider had not re-applied to the local authority.
• During our inspection the provider was unable to provide us with evidence of any DoLS authorisations in place . After the inspection the provider confirmed two people had authorisations in place from January and February 2019.
• We were concerned that people were not able to consent to the care they received and they were being deprived of their liberty unlawfully. For example, one person had bedrails in place, although the provider said these were not in use a staff member had told us they were used. In addition, two people's care records suggested staff should use holding techniques when people's behaviour challenged the service. Without the right legislation in place these people were at risk from being restrained unlawfully. The provider told us they did not use restraint on anyone and would remove the person's bedrails. They also assured us they would follow up the DoLS applications made for people.

These concerns constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• People were not always involved in decisions about the premises and environment. Staff told us people were non-verbal and gaining people's views was difficult.
• One person's room was decorated with pictures and personal items, they told us through gestures that the walls were painted in their favourite colour and they played us some music and showed us their belongings. However, all the other rooms we viewed were plain, bare walls with no attempt to make them homely, comfortable or personal to the person. Staff told us people "broke" things or were at risk from certain objects, so they were taken away to protect people.
• We asked if people had been involved in decisions about the decoration of their rooms, the provider confirmed most had not, but he had spoken to family members instead. We asked if the provider had accessed any best practice guidance in this area. The provider confirmed they had not but had taken a common-sense approach to decoration and maintenance issues, such as the tiled floors and plain walls in two people's rooms. After the inspection the provider sent us evidence of work completed on one person's room showing the improvements made to personalise their bedroom. We were also provided with evidence of consultation with one person's relative who had been consulted regarding the ongoing decoration and maintenance of their family members room.
• The environment did not always meet people's needs. There was a lack of toilet and hand washing facilities on the ground floor, there was no communal toilet and the only communal sink for hand washing was in the laundry area. One room on the ground floor did not have any en-suite facilities so the person needed use the communal bathroom and toilet on the first floor. The person had difficulty using the stairs and required staff support or would be at risk of falling.
• Building and decorating work was underway to improve the internal living environment of the home. The provider explained there were plans for creating a communal shower room and toilet on the ground floor and told us these changes would happen in the next few months.
• The provider did not always act, without delay, when property needed essential maintenance or replacing. This meant people were at risk of harm. For example, one person's bedroom door was badly damaged. It would not meet fire regulations and presented a risk of injury to the person.

Although the provider was making improvements to areas of the service during our inspection, the concerns raised above had not been addressed at the time of our inspection. At the time of the inspection these concerns were outstanding and a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Family members told us they felt involved in people's care and were told when there were changes in people's needs. We spoke to one person's advocate who told us the service was good at responding to people's health needs. They said, "They are very reactive to [person's name] needs." They told us the person was due to have a hospital appointment soon and explained how family had been involved and staff would go with the person to the hospital to help relieve any anxiety they may feel.
• Records contained details of appointments with healthcare professionals and follow up appointments needed. However, some communication with healthcare professionals was poor. Where people had been referred to learning disability services advice and recommendations were not always followed. For example, we found two instances where the service had been advised to maintain records to monitor people's behaviour, but this had not been done. There was also advice on how best to communicate with people, but these recommendations had not been actioned. We spoke to the provider about our concerns and they assured us they would begin to monitor people's behaviour in more detail.

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

• People could eat their meals either in the dining room or the kitchen. Staff told us people had no specific dietary needs and food was good. We observed food was good quality and well presented.
• The menu rotated on a four-week basis and had been in place since 2015. Staff told us this had been created with the help of a speech and language therapist and had not been reviewed since this date.
• We asked staff how they involved people in decisions about their food and drink and offered them choice. Staff told us that although the menu had been in place or a long time and was not discussed with people they would offer people alternatives if they did not like the menu option of the day. We observed one person being offered an alternative during our inspection.

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

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

Respecting and promoting people's privacy, dignity and independence
• People' privacy and dignity was not always respected.
• When we first arrived a member of staff showed us around the service, they did not knock on bedroom or bathroom doors and allowed us to walk into people's rooms without gaining their consent. One person's room on the ground floor was locked and we were able to ask their permission. They were able to show us there room independently. After the inspection the provider wrote to us to assure us that staff were always polite when entering people's rooms. However, when staff knew people where elsewhere in the building they were not expected to knock or let the person know before entering their rooms.
• People's privacy was not always maintained. One person's bedroom on the ground floor had two clear windows and a plastic and glass door directly looking into a ground floor communal lounge area. There were no coverings to give the person privacy and people were able to look directly into their room. The provider told us the person would pull any curtains down but had not considered other alternatives to give the person privacy. After the inspection the provider assured us action had been taken to rectify this situation.
• Staff told us one person's shower was broken. Staff told us they showered the person using a bucket of warm water and a jug and this had been in place for at least a month. The person's care records suggested they preferred baths, but we were told the bath in their en-suite was broken. The person's care records had not been updated to reflect this change.
• Although the provider explained work was in progress to replace the shower and showed us the new fixtures and fittings they had purchased we were concerned the arrangements in place at the time of our inspection did not encourage the person's independence or maintain their dignity. The impact of these changes had not been addressed in their care records.

The issues above were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• People were not always supported to express their views.
• A relative told us they thought their family members communication skills had reduced since living at Ashleigh House. They felt a lack of continuity in staffing meant staff did not have the opportunity to get to know their family member well and this had had an impact on their ability to communicate.
• The provider told us people living at the service were non-verbal, so it was difficult to communicate with them. They told us, "We record the views of people via their parents and parents voice what is happening."
• Staff told us of one person who was able to use a hand-held computer, when they pointed at a picture of

their relative staff knew the person wanted to contact their family member. We discussed this method of communication with the provider and how technology could help people express their views and be involved in decisions.
• People had keyworkers that were staff members they were familiar with. The provider confirmed regular keyworker meetings were held and after the inspection we were sent some examples of these meetings. Although they gave a good overview of what was going on in people's life's it was hard to see how people were involved in decisions and choices and how staff had established people's views.

The issues above were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
• Relatives told us they thought staff were caring and were happy with the staff and the service.
• We spoke with a visiting activities coordinator who told us they thought the service was caring and focused on people as individuals. They told us, "Staff are always welcoming and interacting with people. They are very good."
• We observed staff were caring towards people and saw some positive interactions between staff and people. For example, one person made it known they wanted to use the toilet and a staff member discreetly escorted the person away from the communal area to give them support.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People's needs were assessed when they first started to use the service and regular reviews were conducted to ensure people received the care and support they required. However, we found some other documents within people's care records were out of date. For example, one person's hospital passport was last reviewed in September 2017 and another person's MCA assessment was completed in October 2017 and had not been reviewed.
• Although people's care records were personalised some information was conflicting. For example, one person's summary care plan reviewed in March 2019 stated a person could independently use the toilet, while their risk assessment, updated in August 2018, spoke of staff needing to change their incontinent pads on a regular basis.
• The service did not fully understand people's information and communication needs. Although care records were focused on individual needs and contained some detailed information on how best to communicate with people, including communication profiles. We did not see sufficient evidence of how the Accessible Information Standard had been applied to support people to make decisions about their care and treatment.
• People were not always supported to express their views and make decisions about their care. The provider explained they fully involved people's family members to make decisions about their relatives care but the service did not explore the views of people living at the service. For example, healthcare professionals had recommended a range of techniques for staff to use to help involve people in their day to day care, but we did not see any of these in use during our inspection.
• We spoke to the provider about following the guidance and advice given to them by healthcare professionals. This would help people become more involved in their care and enable them to make decisions in their everyday life. The provider confirmed they would look at ways to meet people's communication needs.
• Although care records recognised communication could be a risk factor to people's behaviour, triggers and clear communication strategies were often not in place for staff to follow. Only one person had a positive behaviour support plan in place, this had been copied from their previous placement. (This plan helps staff support people as individuals when they display or are at risk of displaying behaviours which challenge. It helps staff understand the reasons for the behaviour and gives guidance on the best way to support people). We were concerned because without this information staff may not support people in the best way to ensure positive outcomes.
• We observed people going out on activities during our inspection. For example, everyone was taken to the pub one afternoon for something to eat. On the second day of our inspection people were encouraged to participate in arts and crafts or make music with recycled packaging.
• Staff told us people liked to go out for a drive or to the park to play football.
• People's activity plans did not always coincide with what they were doing and when we looked at records

we noted staff had recorded many activities as, "went for a drive" and "relaxed in the lounge". The provider explained that a drive may mean going to the park to feed the ducks or to play football and there were limitations to the activities some people could do because of their needs. We discussed ways of making notes clearer, so people's hobbies, interests and activities were fully recorded.

The issues above were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure in place and confirmed they had not received any complaints in the last year.
• Relatives we spoke with said they had not needed to make a complaint however they knew who to contact if they had concerns and felt any issues would be dealt with.

End of life care and support
• At the time of our inspection no one at the service was receiving end of life care. The provider gave us assurance that they would put the policies and procedures in place to enable them to provide this care and support when it was needed.

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

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

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• The provider had some systems in place to review the quality of the service. This included regular audits of medicines management, some care records, fire safety and checks of fridge and freezer temperatures. However not all of people's care records were reviewed when they should be and some people's care records were not accurate.

• The provider did not keep a record of DoLS applications made to the local authority to make sure people were being deprived of their liberty lawfully. The provider did not keep central records of staff training so there was no assurance that staff had received the training they needed. After the inspection the provider sent us a spread sheet they had created to keep track of DoLS applications. The also provided evidence of staff training that was not available to us during the inspection. This helps give us assurance that going forward systems are in place to monitor progress in these areas.

•People's risk had not always been identified and recorded. The provider had not recorded the works that needed to be completed or identified the additional risk to people because of the outstanding maintenance and infection control issues.

• The provider did not always use the information from health care professionals to make improvements to people's care.

• Systems did not allow the provider to allow for safe recruitment practices.

The provider was in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

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

• The service had a registered manager in place who was also the provider. 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 provider was supported by his wife, the deputy manager and two administration support officers who were also family members.

• The provider was aware of the need to notify CQC of certain changes, events or incidents that affect a person's care and welfare. However, they had not sent us a notification required to inform us when an outcome of an application to deprive a person of their liberty was received. We spoke to the provider about the authorization received in January 2018 and the failure to notify the CQC of this change. The provider explained they were unaware of their responsibility to report on DoLS authorisations.

This related to a breach of Regulation 18 Registration Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People's family members told us they felt involved in their family members care.
• People were not asked about their views and experiences of the service and the provider relied on feedback from family members to make improvements to the service. Surveys were sent to family members for their feedback, the last survey sent was in 2015 and responses were positive.
• Regular staff meetings were held to share information and provide updates to working practices. Staff felt well supported by their managers and comfortable reporting any issues or concerns.
Continuous learning and improving care; Working in partnership with others
• The provider told us of the links they had formed with Surrey Country Council and the training opportunities available to them.
• The provider worked closely with local authorities when safeguarding concerns were raised.
• The provider spoke about the need to make improvements following our inspection and was keen to take action as soon as they could to make the service better for people.