Mr & Mrs D B Mirsky

# Dorriemay House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

At the last inspection on 23 November 2017 we rated the service requires improvement. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions, Safe, Effective, Responsive and Well-Led to at least good. At this inspection we found the action plan had not been effective in raising standards at the service and the quality of care people received had declined. People were not safe and the service was not well led.

Dorriemay House provides care and support to people living in five 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. People using the service lived in 14 ordinary flats and bedsits across Margate and a single 'house in multi-occupation' shared by 20 people. Houses in multiple occupation are properties where at least three people in more than one household share toilet, bathroom or kitchen facilities. People living in the house shared two kitchens and two lounges. There was an office on site. There was also a café where people living in the house or in flats could purchase meals.

Not everyone using Dorriemay House receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The 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 could not live as ordinary a life as any citizen.

A registered manager was working at 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 registered manager did not fully understand the requirements of registration and had not notified us of some events that had happened at the service so we would check the appropriate action had been taken.

The provider and manager had not kept up to date with changes in good practice around the care and support of people with a learning disability. They had not developed a positive culture at the service and people were not referred to in respectful ways, valued as individuals or fully involved in planning the service they received. They did not always have privacy.

The quality of the service was not kept under review. The provider and registered manager relied on staff to complete checks and audits and did not know they were not up to date. They were not aware of the shortfalls we found during our inspection. People had been asked for their feedback about the service but

their views had not been acted on.

People were not protected from the risk of harm or abuse. Concerns people raised had not been listened to and action had not been taken to support people to keep themselves safe. Complaints people raised were dismissed without being investigated.

Risks to people have not been comprehensively assessed and action had not been agreed with people about how to keep them safe while they developed their independence. Clear guidance had not been provided to staff about how to support people with the risks associated with health conditions. Some people had behaviours which challenged staff. Guidance had not been given to staff about how to support people to manage these behaviours. Where guidance had been provided by health professionals staff did not know about it and it was not followed. The registered manager did not know about good practice around behaviours which challenged.

People's medicines were now stored in their home, however the registered manager had not acted on our recommendation to consider guidance on managing medicines for adults in community settings and staff had not been given some of the information they needed to support people to manage their medicines safely.

Staff were not recruited safely or supported to develop the skills, knowledge and experience they needed to care for people. People did not receive all the care they needed because the registered manager had not planned staff deployment to meet people's needs and to the levels commissioned by the local authority.

Records about people were not detailed. Information was not available about areas of people's care and no information was available about one person. Staff relied on people and each other for information as they did not have time to read people's care plans.

People had not been supported to plan and achieve goals and planned care was not regularly reviewed with them to make sure it reflected their needs and wishes. Assessments of people's needs before they began using the service were very basic and the provider relied on the local authority referring people whose needs the service could meet and providing them with all the information about the person. People, including those who were older or unwell had not been supported to share their wishes and preferences around their care at the end of their life.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Some people were not given choices in ways they understood. The registered manager had not acted on our recommendation to consider current guidance on the principles of the MCA and take action to update their practice accordingly.

The provider had not taken action to comply with the assessable information standard and only the complaints process was available in an easy read version.

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

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

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

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

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

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?

**Inadequate**

The service was not safe.

The registered manager had not always identified and reported safeguarding concerns.

People were not always protected from risks or harm.

Staff were not recruited safely.

Staff had not been deployed to meet people's needs.

People's medicines were not always managed safely.

Staff managed the risk of infection.

### Is the service effective?

**Inadequate**

The service was not effective.

People's needs were not assessed.

Staff were not supported to provide effective care.

People were not supported to make choices in ways they understood.

People were not always supported to manage their health care needs. Staff had made referrals to healthcare professionals when people's needs had changed.

People were supported to eat and drink safely.

### Is the service caring?

**Requires Improvement**

The service was not caring.

Staff did not always refer to people in a respectful manner.

People were not supported to be as independent as possible.

People were not always supported to communicate their needs

and preferences.

People did not always have privacy.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People were not supported to plan their care and support.

People were not supported to develop their independence and learn new skills.

People's complaints were not listened to.

People had not been supported to plan their care in the way they preferred at the end of their life.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The registered manager had not kept their skills and knowledge up to date and did not know about good practice for the support of people with a learning disability.

We had not been notified of important events that happened within the service.

Checks and audits had not always completed and had not identified shortfalls highlighted at this inspection.

People views had not been acted on to improve the service.

# Dorriemay House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 15 and 16 January 2019 and was announced. We gave the service 24 hours' notice of the inspection visit because we needed to be sure that people who wanted to speak to us were available during the inspection. The inspection team consisted of two inspectors, and an expert by experience in the care and support of people with a learning disability. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Inspection site visit activity started on 15 January and ended on 16 January 2019. It included meeting and speaking to people who use the service and interviewing staff who supported them. We visited the office location both days to see the registered manager and to review care records and policies and procedures. We looked at five people's care and support records and associated risk assessments. We looked at four people's medicine records. We looked at management records including four staff recruitment, training and support records. We observed people spending time with staff. We spoke with the registered manager, supervisor, two senior support workers and three support workers and 9 people who use the service and their relatives.

Before the inspection we asked the provider to send us a Provider Information Return (PIR). 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. Due to a technical problem we did not received the PIR. The registered manager gave us a copy of the PIR during our inspection and we reviewed this alongside other evidence we gathered during the inspection. We also looked at 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 asked for feedback on the service from the community professionals who had involvement with the service and staff.  We received information from the local authority safeguarding and

commissioning staff and two care managers.

We asked the registered manager to send us information about the service, including their statement of purpose and minutes of staff meetings. We did not receive this information.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe when they received a service from Dorriemay House staff. However, we found that people were not safe and had not been protected from harm and abuse.

People were not protected from the risk of financial abuse. Assessments of people's money management skills had not been completed and support had not been planned with them to develop these skills. For example, staff had supported one person to spend £100 in five days on day to day laundry. The person used the provider's coin operated washing machine and tumble drier at a cost of £7 a load. Staff had not explored more affordable ways for them do their laundry. We raised a safeguarding alert with the local authority safeguarding team about our concerns.

Some people told us they locked their room or flat and their property was safe. However, other people chose not to lock their room or relied on staff to support them with this. These people's property was not safe and there was a risk that other people living in the building may take it. Staff had removed some items, including prescribed creams, from people's rooms and locked them away in another area of the building. People's creams and toiletries were not stored in their home and were not easily accessible to people and staff when they needed them. People had not been asked if they wanted to store their items away from their homes. The registered manager blamed people for not locking the bedrooms doors but had not considered their wishes or any support they may need. Care had not been planned to support people not to take other people's things.

Action had not been taken to keep people safe when they had been the victim of abuse. Robust plans had not been put in place to support one person after an incidence of abuse, including how to reduce the risk of the abuse occurring again.

One care manager told us the registered manager had not acted when one person raised concerns about an allegation of abuse and had only acted when instructed to do so by the care manager. The registered manager confirmed this but dismissed the person concerns as "It's all unfounded nonsense".

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

People were not protected from the risks of unsafe care. There was a risk people living with epilepsy would not receive the care and treatment they needed when they had a seizure. Staff did not know some people were epileptic and there was no guidance about the action to take if they had a seizure. Experienced staff told us about the action they needed to take to care for one person who had frequent seizures. However, detailed guidance was not in place and there was a risk that new staff would not know what action to take to keep them safe. Guidance for another person was contradictory and this may have caused a delay in emergency medical support being obtained for the person. The registered manager and staff were not able to tell us which of the guidelines was correct.

The risk of people falling had not been assessed and guidance had not been provided to staff about how to support people to remain safe and minimise any restrictions on them. We observed a staff member place a chair in front of a person when they left them alone. The staff member told us they did this as the person often tried to stand and was at risk of falling. Care had not been planned to reduce the risk of the person falling. The person was also at risk of falling while walking. Detailed guidance had not been provided to staff about how to support the person and no guidance was in place about the support the person needed to climb the stairs. The person's care manager told us before the inspection an occupational therapist (OT) had visited the person to assess their ability to climb the stairs but staff had not supported this assessment and the OT had not been able to assess their needs and offer advice about any support they needed.

Some people were at risk of choking and detailed guidelines to prevent choking had been given to the person by a speech and language therapist. Staff prepared the person's food and drinks in accordance with the guidance including using adapted cutlery and crockery. However, staff did not know why the person used a 'plastic spoon'. Staff were not aware of the guidance in the person's risk assessment about how to respond if the person choked. They told us two staff would be needed to provide first aid to the person, this was not included in the risk assessment.

Risks related to diabetes had not been assessed and guidance had not been given to staff about how to identify and respond to changes in people's health. Staff told us one person enjoyed lots of sugary foods and would purchase these for themselves. One staff member told us if they saw signs that the person was becoming unwell they would call the person's GP or take them to the hospital. Staff did not know how to support the person to reduce their blood sugar levels or at what point to seek medical advice. Care had not been planned to support the person to understand the risks to their health from eating sugary foods. Following our inspection safeguarding concerns were raised by healthcare professionals who were worried that staff did not know a person who had become unresponsive was diabetic. These concerns are being investigated by the local authority safeguarding team.

Some people told us other people they lived with "shout and say nasty things" and they did not like this. Before our inspection care managers told us, there was a lack of risk assessments and guidelines for staff who supported people with behaviour that challenged. We found guidance was not available about the support some people needed, despite the registered manager telling us in the Provider Information Return (PIR), 'Staff follow instructions on individual care plans to manage challenging behaviour'. Staff did not know about the guidance for other people and did not support them consistently. Records showed one person regularly had behaviours that challenged. Staff had not supported them to follow the guidance from their community nurse and the person had not calmed. The registered manager and staff did not have the skills to support people with behaviours that challenged and had not completed training. The registered manager did not know about positive behaviour support which is best practice when supporting people with a learning disability.

Incidents of behaviour that challenged were not recorded in detail and there were no systems in place to analyse them to look for patterns and trends and ways of reducing them happening again. For example, incident reports showed that one person had refused their medicine on occasions and staff said they did this regularly. Action taken to support the person to take the medicine had not always been recorded. The registered manager told us staff always supported the person to take the medicine later however we found the person had missed at least three doses of their medicine.

The provider and registered manager had failed to assess risks and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had practiced the action to take in the event of a fire with staff and this helped them feel safe.

At our last two inspections we found medicines processes required improvement and recommended the provider consider current guidance on managing medicines for adults in community settings and take action to update their practice accordingly. At this inspection we found changes made had not improved medicines safety.

There continued to be no guidance about people's 'when required medicines', including the signs the person may need the medicine. Some people had over the counter medicines for minor ailments which staff administered. People's GP had not been asked if the medicine was safe for the person to take.

In their PIR the registered manager told us, 'administration of medication is discussed with the tenants and an assessment of what support is needed is completed'. We found assessments of people's ability to manage their medicines had not been completed and support plans had not been put in place. Medicines however were now stored in people's rooms and flats.

The application of prescribed creams was not recorded consistently and their continued to be no guidance about where and how often to apply prescribed creams. One person told us their GP had recommended they stop using a prescribed cream and use an over the counter alternative which staff applied. The person's care plan had not been amended to reflect the change and the staff member responsible for overseeing medicines management had not been informed.

The provider did not have a process in place to manage medicines and was using the National Institute for Health and Care Excellence (NICE) guidance. NICE guidance was not followed and robust arrangements were not in operation to train staff and assess their competency annually. Everyone's medicine were stored in a monitored dosage system without an assessment by a health professional to identify their medicines support needs and preferences.

The provider and registered manager had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to meet people's needs. Before our inspection a care manager told us, it was not clear how the registered manager deployed staff to meet people's needs. We observed support staff rushing around to ensure people's basic care needs were met. They did not have time to spend with people and we observed some vulnerable people did not have any interaction from staff or others living in the building for long periods of time. Staff told us this was usual and people did not always receive the care they needed. One incident record showed this had impacted on a person's behaviour and they had become frustrated when staff had not had time to support them to do something they needed to do. The registered manager told us several times during the inspection people did not received the number of support hours care managers had assessed were required to meet their needs. They said, "[The local authority] pay and I do my best to cover it. All care plans say how many hours people are supposed to have but I would be broke if I did what care managers wanted".

Rotas showed that usually there were three senior support workers with two support workers in the morning and three support workers in the afternoon Monday to Friday. There were three support workers in the morning and two in the afternoon at the weekend. Staff told us weekends were very busy as staffing levels were considerably reduced and people were not out at college or day services. No one prepared their own

meals at the weekend and one staff member spent most of their time preparing meals. At the time of our inspection there were two waking staff at night. On occasions when a member of night staff was sick, a member of day staff completed a sleep-in shift. The registered manager told us they were considering having one wake staff and one sleep-in staff all the time. They had not previously considered some people needed two staff to support them at times and this left them at risk.

The provider and registered manager had failed to deploy sufficient numbers of staff to meet service user's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not protected by safe recruitment practices. Checks on staffs' conduct in previous employment working with vulnerable people had not to be completed. Gaps in staff's employment history had not been identified and explored. The provider told us in their PIR, 'staff are checked on recruitment, references followed up'. However, we found there were no references for one staff member and checks on their conduct in previous care roles had not been completed. There was one reference for another three staff. References had not always been requested from the most recent employer. One reference was from a previous employer however it was pre-prepared and no checks of the reference had been completed. One reference was dated after the person began working at the service.

A Disclosure and Barring Service (DBS) criminal record check had not been obtained for one staff member working alone with people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. A full employment history had not been obtained for staff, so the registered manager did not know the roles they had held and why they had left.

The provider and registered manager had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service was clean; however, people were not supported to keep their own rooms or flats clean and tidy. The registered manager told us they had arranged for people to purchase cleaning services as part of their rent because some people did not clean their home to the standard the registered manager liked. They told us, "They cannot live in a mess and make my house smell". The registered manager had not recognised that people were able to choose how they lived in their own home and had not planned with people the support they needed to keep their home safe. Most staff completed training in infection control and hand hygiene and we observed the following safe practices.

Inadequate

# Is the service effective?

## Our findings

A comprehensive assessment of people's needs, preferences and goals was not completed with them before they began receiving a service from Dorriemay House. We looked at an assessment for one person who had recently begun to use the service. It contained very little information about the person and had not been shared with staff. Staff told us they did not know about the person and were gradually getting to know them, including behaviours which challenged. The registered manager told us they relied on information received from people's care managers and this had not arrived for several weeks after the person began receiving a service. Assessments of people's needs were not completed once they began receiving a service.

A system was not in operation to check staff could meet people's needs before they began using the service. The registered manager relied on the local authority staff referring people to make this decision. They told us, "Social services wouldn't send us anyone we couldn't cope with". The registered manager had not considered the needs and personalities of people already using the service, alongside those of anyone they were considering offing a service to, when people living in shared accommodation. A case manager told us, 'The service doesn't always consider the mix of people when agreeing to placements'. We observed that people did not always get along.

The provider and registered manager had failed to carry out, collaboratively with service users, an assessment of the needs and preferences for care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. 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. Where people are at risk of being deprived of their liberty and live in their own homes applications must be made to the Court of Protection. No one had a DoLS authorisation in place. The registered manager told us they had discussed DoLS with some people's care managers since our last inspection and that no DoLS were required.

At our last inspection we recommend the registered manager consider current guidance on the principles of the MCA and take action to update their practice accordingly. At this inspection the registered manager told us they had not acted on this recommendation and neither they or staff had completed training in the MCA. We observed some people making decision without support about their lives, including what they did and where they went. However, other people needed support to make decisions. Guidance had not been provided to staff about how to support these people to make decisions. We observed some people were not give the opportunity to make meaningful decisions about their life and the service they received. For example, staff made a drink for one person without asking them what they would like to drink. The person's care manager told us the person was able to choose between two things if they were shown them.

People's capacity to make decisions had not been assessed including managing their money and consenting to their care. For example, people did not hold their bank cards and these were held by the

registered manager. Care had not been planned to support people to hold their own cards and money and we observed people asking and checking that even small amounts of money would be available at the weekend when senior staff were not on duty. The registered manager told us that capacity assessments had been completed for everyone in relation to the administration of medicines. However, they were unable to show us any.

The provider and registered manager had failed to act in accordance with the Mental Capacity Act 2005 to obtain lawful consent to care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People did not receive consistent support to manage their healthcare needs. One person needed to drink a specific amount of fluid each day to prevent them becoming dehydrated and reduce the risk of them getting an infection. The amount the person drank each day was recorded. We reviewed these records and found that the person was not offered a drink for two hours after they got up each day and there was regularly a gap of 12 hours between the person's evening and morning drinks. The person often drank below the required amount and on one day drank only half of the required amount. A process was not in operation to check the person had drank the required amount each day and staff were not aware of that there were long gaps between drinks or that the person was not always drinking the required amount.

Staff did not always have up to date information about everyone's health care needs. Some people chose to receive support from their relatives to attend health care appointments. Action had not been taken to find out and act on advice received from healthcare professionals when this was not shared by the person or their relatives. This put people at risk of not receiving the best support to manage their healthcare needs.

The registered persons had failed to design care with a view to ensuring their needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff had information about other people's needs. When people chose to stay with relatives when they were unwell staff supported them at their relative's home. A care manager told us, "Staff supported [the person] at their relative's property and were very supportive to the family", the person's family confirmed this.

Staff identified any changes in people's health and supported them to see their health care professionals. People had regular health checks including dental checks. People had hospital passports to tell staff and health care professionals about their health care needs.

Staff had not been supported to develop all the skills and experience they needed to meet people's needs, including supporting people with behaviours which challenged. A care manager told us, 'Some staff take people's behaviour very personally and do not take a positive view to managing or minimising behaviours. In some cases, I feel that this has resulted in a rather 'parental' negative view from staff or that any behaviour is deemed as just unreasonable regardless of the specific circumstances to which it may have occurred'. We found on occasions staff had recorded people's behaviour as challenging without considering the behaviour, for example, refusing medication. Other records showed staff had followed people immediately after an incident of challenging behaviour requesting an apology and people had continued to be angry.

Staff had completed on line training in a number of subjects which included a skills test. Further assessments of staff's competency to complete their role had not been completed. Several experienced staff had left since our last inspection and new staff had been employed. New staff did not complete any training as part of their induction and worked through 'workbooks' and shadowed other staff. Four new staff had not

completed most of the training the provider required. One staff member who was administering medicines had not completed the provider's training and their competency to administer medicines safely had not been assessed. The registered manager had plans in place to provide face to face training in some subjects including emergency first aid, fire safety, health and manual handling in 2019.

The provider and registered manager had failed to ensure staff were appropriately trained and competent to carry out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were advised about healthy eating; however, some people chose not to follow this advice. Staff supported to shop for and prepare meals. We observed one person being supported with their meal. The staff member sat with the person and supported them at their own pace.

Requires Improvement

# Is the service caring?

## Our findings

People were not always treated with respect. The registered manager described people as "manipulative", "demons", "difficult" and "has a wooden spoon and winds everyone up". Staff described people as "intimidating", having "rages" and "will get in your face". People were not referred to respectfully in their records and were described as, 'illiterate', 'I don't like being told what to do', 'short tempered', 'stubborn' and requiring 'feeding'. We observed staff speaking to people respectfully.

People had not been given opportunities to discuss their sexual orientation or gender identity so support could be planned to respect their choices and keep them as safe as possible. Some people had made their preferences known to staff and these were respected. However, other people had not been asked about their preferences. The registered manager and senior staff knew about some people's preferences but staff supporting people on a day to day basis did not know and care had not been planned with people to enable them to live their life as they choose with support to remain safe. Some people were in relationships and staff respected these. People had not been asked about any preference they had for the gender of the staff member who supported them.

People were referred to by their preferred names and were relaxed in the company of staff. Staff treated people with care and had a genuine interest in people. People told us staff were kind and caring. However, staff did not have the time to give people all the attention they needed. We observed the only interaction between staff and one person was to support them to meet their basic needs. The person spent the rest of the time sat alone and staff reset their game on occasions.

Staff knew what caused people to become anxious but did not always give them the support and reassurance they needed. For example, one person had behaviours that challenge. Guidance in relation to their behaviour was to leave them alone to calm down. However, an incident record stated a staff member had followed the person after an incident and asked for an apology and the person had continued to be angry.

People were not consistently supported to develop independent living skills. Some people told us they prepared meals, snacks and drinks for themselves. Other people needed support to prepare some meals. At lunchtime we observed staff preparing a meal for one people, including stirring pans, while the person who was able to complete the task, chatted to their friends. We observed other people continued to do things for themselves.

People received their care in private. We saw staff knocked on bedroom and bathroom doors before entering. However, people told us that cleaning staff did not always knock before entering their flats and bedrooms. One person said, "The cleaning ladies don't always knock on the door before they come into my room. The staff do". Staff kept personal, confidential information about people and their needs safe and secure.

People were supported to keep in touch with their friends and relatives and told us how staff supported

them to visit them regularly.  People were supported to celebrate special occasions at home with their friends. One person told us how staff had asked them what they wanted to eat on their birthday and had cooked the meal of their choice for everyone. They told us they had enjoyed their birthday.

People who needed support to share their views were supported by their families, care manager or paid advocates.

Inadequate

# Is the service responsive?

## Our findings

At our last inspection we found information and guidance to staff about people and their needs was not always detailed. Before our inspection a care manager told us, 'Paperwork has improved slightly but still needs work to ensure new staff know exactly how to support an individual'. We found that people's care plans and other records lacked detail and did not provide staff with the clear guidance they needed to provide consistent care. No guidance had been given to staff about how to support one person. The registered manager told us this was because, "We are learning about [the person]".

Support staff told us they had not read people's care plans as they did not have time and had learnt about people from asking questions of the person or other staff. Some staff did not know about the basic care people needed. For example, one staff member who had worked at the service for over a year, did not know a person required two showers or strip washes every day and told us the person did not receive these. Some people told us they had care plans which were stored in the office. People did not have copies of the care plans in their homes.

People no longer discussed their goals and ambitions with staff. Support had not been planned with people about how they would develop the skills they needed to live as independently as possible. Some people continued to complete some domestic tasks with staff support such as shopping for and preparing some of their own meals. However, people's progress had not been reviewed to check if their independence had increased or if alternative support was required.

People had not been involved in reviewing their care. We looked at five people's care plans which had been written in February 2018. These had not been reviewed to make sure they remained current.

At our last inspection the registered manager had plans in place to improve the support they offered people to consider their wishes for the end of their life care. These included working with health care professionals. Since our inspection no work had been done with people to plan their care at the end of their life including understanding their wishes and preferences. This was important as some people were older and other people's health was changing.

Some people told us about local groups they were part of, including walking groups and clubs where they met other people to chat and have discussions. Other people continued to do voluntary work which they told us they enjoyed. Some people went out and about without staff support, however other people needed staff to support to go out. Staff told us that two people with complex needs were not supported to go out. They told us previously these people had enjoyed going out. One staff member had recently begun to facilitate an 'activities evening' once a week in the communal area of the building, which people were able to attend if they wanted to.

From April 2016 all organisations that provide NHS 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 registered manager was not meeting the Accessible Information Standard. They had not considered accessible ways of communicating with people, such as pictures and symbols, to support people to tell staff about their needs and wishes and be involved in planning their care.

At our last inspection we recommend that the registered manager consider current guidance on accessible communications and take action to update their complaints process accordingly. At this inspection we found that an accessible version of the complaints process was displayed in the entrance to one building were people lived. However, other documents relating to complaints, such as the complaints form people could use to raise a complaint had not been written in an accessible way.

The provider and registered manager had failed to design service users' care with them to achieve their preferences and ensuring their needs are met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us if they had any concerns they would tell the registered manager, staff, their family or care manager. One person's care manager told us, 'I do not feel that clients voicing concerns have been taken seriously' and gave us an example of a complaint that had not been resolved and had led to the complainant having behaviours which challenge. The registered manager was dismissive of people's complaints and told us they had not received any complaints about the service.

One person had complained about the way a staff member had spoken to them and had requested that the staff member did not support them again. This had been recorded on a 'contact form'. The action recorded was 'Will speak to [registered manager] about this'. We asked the registered manager what action they had taken in response to the complaint. They told us they had taken advice about the staff member and they no longer worked at the service. They were not able to tell us how they had responded to the complainant and if the complaint was satisfied with the action taken. No records have been maintained about the complaint and how it was resolved.

The provider and registered manager failed to act on feedback from people on the service provided, for the purposes of continually improving the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

# Is the service well-led?

## Our findings

Dorriemay House is registered by the Care Quality Commission to provide care and/or support in order to promote people's independence in their own homes. The provider owned the properties people lived in under a different legal entity and the registered manager told us people had to receive their support from Dorriemay House if they lived in accommodation owned by the provider. Care managers told us the service was run as a residential home rather than a supported living service and there did not appear to be a genuine separation between the care and the accommodation. We are taking action to ensure the provider is correctly registered with CQC.

The service was not well led by the provider and registered manager. They did not have a clear vision and a set of values which underpinned the service people received, including a person-centred culture, independence and respect. Staff had not been supported to develop the skills and attitudes they needed to provide people with a service tailored to their needs and preferences which supported them to live as independently in the community as possible.

At our last two inspections we found the provider and registered manager did not operate effective systems to assess and improve the quality of the service. At this inspection we found effective action had not been taken to address this continued breach of regulation.

The provider was not involved in the day to day running of the service and did not have oversight of the how the registered manager ran the service. The provider had not completed any checks on the service people received. Effective checks had not been completed by the registered manager and they had delegated this task to staff. The last check had been completed in November 2018 and a shortfall in the 'appropriate information governance systems in place' was noted. No action had been planned to address this shortfall. The provider and registered manager were not aware of the shortfalls and breaches of regulation we found at our inspection.

Following our last inspection, the provider sent us an improvement plan telling us how they would improve the service to a good standard. The registered manager told us they had completed 75% plan. They felt their biggest challenge was recruitment of staff and that the recording processes put in place since the last inspection to make improvements had not been completely successful. We found the improvement plan had not been effective and risks to people had increased.

A care manager told us the registered manager had an 'institutional outlook' and the service people received had 'declined'. Our inspection found this was correct. The provider and registered manager had not kept up to date with changes in practice to support people with a learning disability, such as managing medicines in the community, person-centred planning (a way of helping a person to plan their life) and person-centred active support (a way of supporting people to be as independent as possible). The registered manager was not part of and forums of networks to support them to remain up to date with best practice, such as the local registered managers network, a group of like-minded colleagues who face similar, everyday challenges.

People had been asked for their experience of the service but their responses had not been acted on. Seven people had responded to the last quality questionnaire and their comments included, the need for more staff, support to go out more often and support to take part in pastimes at home. Feedback received had not been analysed or acted on. Other ways of understanding people's experiences had not been explored. The registered manager told us 'tenant meetings' were no longer held because they were too difficult to arrange. Feedback from three healthcare professionals had been received by the registered manager and was positive.

Some staff told us they did not feel supported or appreciated by the provider or registered manager. One staff member commented, "They say things but nothing gets done". Other staff said that suggestions they made were listened to and acted on. All the staff said that there were not enough staff to meet people's needs and they were motivated by the people using the service.

The provider and registered manager had continually failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager failed to act on feedback from people on the service provided, for the purposes of continually improving the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found some records about people's care and support had improved and the registered manager had identified that further improvements were needed to make sure staff always had detailed and up to date information and guidance to refer. The improvements the registered manager had made had not been effective. Staff continued not to have the detailed information and guidance they required to provider consistent support to people.

Records we asked the registered manager to send to us, including staff meeting minutes, a copy of the medicine management guidelines they were following and a copy of their statement of purpose. We did not receive this information.

The provider and registered manager had continually failed to maintain accurate and complete records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not fully understand their responsibilities with regards to running a regulated service. They did not know that some events including allegations of abuse needed to be notified to us and we had not received statutory notifications as required. Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service so we can then check that appropriate action had been taken.

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

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 judgments. We found the provider had conspicuously displayed their rating at the service. They had displayed the rating on their website for Marbleside Care but had not explained that Marbleside Care was an informal name for the registered service Dorriemay House.