Life Opportunities Trust

Life Opportunities Trust - 329 Martindale Road

Inspection report

329 Martindale Road
Hounslow
Middlesex
TW4 7HG

Tel: 02085776031
Website: www.lot-uk.org.uk

Date of inspection visit:
02 July 2019
03 July 2019
05 July 2019

Date of publication:
17 June 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Life Opportunities Trust - 329 Martindale Road is a care home situated in a residential street in Hounslow. It is registered to provide personal care for up to seven people aged 18 and over. It supports adults with multiple or complex needs such as profound learning and physical disabilities and who are living with additional conditions, including epilepsy and dementia. At the time of the inspection five people were living at the home. People had their own bedrooms. They shared the kitchen, dining room, living room, laundry facilities, sensory room and garden. A team of staff supported people during the day and overnight.

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

People's experience of using this service and what we found
The outcomes for people did not fully reflect the principles and values of Registering the Right Support. This is because people were not always treated with dignity and respect. People did not always receive person-centred support that helped them to be safe and have good, meaningful everyday lives.

People were not always supported in a caring and respectful way. Staff did not always demonstrate empathy for people using the service.

People were not supported to participate in regular, varied and meaningful activities they could enjoy at home or in the community. People were not supported to have maximum choice and control of their lives and the policies and systems in the service did not support this practice.

Medicines were not being managed safely.

People had complex needs and were not always able to verbally communicate with others. There were not planned approaches in place for how staff should communicate positively with people to meet their communication needs

The provider's systems to monitor and improve the quality of the service had not been operated effectively. They had not made improvements following the areas of concern which we identified at the last inspection despite submitting action plans and stating they would make the necessary improvements. Furthermore, they had failed to identify areas for improvement through their own monitoring.

Safe staff recruitment procedures were not always followed to ensure only suitable staff were recruited to

work at the service. Staff did not always benefit from inductions, training and supervision to develop and be competent in their roles. Staff did not always feel supported by the organisation.

The home environment was not always clean and well-maintained. The provider had made some improvements to the home environment, but more work was still required to improve areas like the bathrooms and to redecorate and personalise people's rooms.

People were supported to eat and drink. There wasn't always an organised approach in place to provide food for or with people to ensure they received a range of nutritious and appropriate meals that reflected their preferences.

People's support and risk management plans set out what their care needs were and described daily routines for how to support people with these. People's plans included some person-centred information about them, including their personal histories, their likes and dislikes and their food preferences.

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

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Rating at last inspection and update
The last rating for this service was inadequate (published 1 February 2019) and there were multiple breaches of regulations. This service has been in 'special measures' since 31 January 2019. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found enough improvement had not been made and the provider was still in breach of regulations.

Enforcement
We identified six breaches of regulations at this inspection. These were in relation to treating people with dignity and respect; providing care to meet people's needs and reflect their preferences; safe staff recruitment and providing appropriate training and supervision; managing medicines and risks to people's safety; and having effective systems in place to monitor the quality of the service.

We took action in line with our enforcement procedures to begin the amendment of the provider's registration to prevent them from lawfully operating the service at Life Opportunities Trust - 329 Martindale Road. Following this we found the provider then made sufficient improvements to the quality and safety of the service and subsequently we withdrew our enforcement action.

Follow up
The overall rating for this service is inadequate and the service remains 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 six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Life Opportunities Trust - 329 Martindale Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors and a pharmacy inspector conducted the inspection over four days.

Service and service type
Life Opportunities Trust - 329 Martindale Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a new manager who had recently started working for the provider. They managed both this home and another care home. They were in the process of applying to register with the CQC at the time of the inspection. The registered manager 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
This inspection was unannounced.

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

the provider had notified us about what had happened at the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
During the inspection we met all five people who lived at the service. The people had complex needs and could not describe to us how they felt about living at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven support workers, the service manager, an administrator and the acting operational manager. We also spoke with three professionals visiting the service. We looked at the support plans for three people, medicines support records, personnel files for four staff and a variety of records relating to the management of the service.

After the inspection
We spoke with one relative of a person who lived at the service and four health and adult social care professionals who have worked with the service.

Inadequate

Is the service safe?

Our findings

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

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

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

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

- Risks to people's safety were not always assessed, monitored and managed so they were supported to stay safe.
- At the inspection on 4 December 2018, we found some people's risk management plans identified support staff needed regular training on supporting people who were using the service living with dysphagia (having difficulty swallowing) to reduce risks of people choking. This training had not taken place. At the inspection on 2 July 2019 we found the people's risk management plans continued to identify this training need and the training had still not been provided. A support worker told us this had also not been discussed at team meetings. This meant the provider had still not taken reasonable steps to ensure people were being protected from the risks associated with dysphagia.
- Staff checked water temperatures around the home each week. Both the forms for recording these checks and people's risk management plans stated hot water temperatures should not exceed 43^{0}C. Checks completed in June 2019 recorded bathroom shower temperatures of up to 45^{0}C on some occasions, presenting a greater risk of injury to people. There were no records of actions taken to address this issue.
- At the inspection on 4 December 2018, we found cleaning chemicals and other potentially hazardous materials were not stored securely. During our visit on 5 July 2019 we again found a chemical used for cleaning in the main corridor which was not stored securely and may have presented a risk to some people using the service. We discussed this with the service manager who told us it shouldn't be there and they took immediate action to remove it.
- Staff supported some people to use hoists and slings to move to and from their wheelchairs and left the slings in chairs under people. On 5 July 2019 adult social care professionals who visited the service confirmed the slings were designed for this use, that the provider had been advised people needed to move position every four hours to avoid the risk of skin damage and discomfort when using the slings, and there were training videos for staff on how to use one person's slings properly. People's support and risk management plans described leaving their slings in place but did not stipulate people needed to change position every four hours. There was no evidence staff had accessed the training on using the equipment safely. We discussed this with the provider who assured us staff would access the training shortly after the

inspection as they had not done so before our visit.
● The provider conducted regular checks to make sure people were safe, such as checking electrical equipment and the general environment. We saw action was taken in response to some of the issues identified by these audits, but some issues were still to be addressed. For example, ensuring the home had a fully stocked first aid box available.

These issues indicated risks to people's safety and wellbeing were not always assessed, monitored and managed so they were supported to stay safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found information for staff on dysphagia did not reflect current recognised guidance. At this inspection we saw support guidance that described food textures using new standardised descriptions was in place for staff to prepare food safely for people who were at risk of choking.
● People's risk management plans identified areas of risk to people's safety and the actions required to minimise those risks. The plans identified areas such as living with epilepsy, moving and handling support.
● On 2 July 2019 we found a clinical waste bin in one of the bathrooms which had no lid and was full past its brim with used continence products, which created an unpleasant odour. The provider told us they were aware of this and had ordered a replacement bin.
● There were fire safety arrangements in place. Fire safety equipment and alarm systems were checked regularly by staff and professional external agencies. We saw that the provider corrected issues these checks identified. There was a fire safety management plan and an evacuation procedure in place. Evacuations were practiced every other month, both during the day or at night People had individual fire evacuation plans setting out how staff were to support people safely in the event of a fire or other emergency. However, we noted some of these plans had not been reviewed by their stated review date. Staff employed directly by the provider had completed mandatory fire safety training so they knew how to support people in an emergency.

Using medicines safely
At our last inspection the provider had not always managed medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

● People were prescribed medicines to be given 'when required'. 'When required' medicines are those given only when needed, such as for pain relief. There was not always person-centred information available to guide staff on when they should support a person to take such medicines. This meant the provider could not always ensure people received their prescribed 'when required' medicines as intended.
● Regular use of 'when required' medicines was not discussed with the prescriber. This may mean that the prescriber was not aware that the symptoms experienced by the person were not controlled effectively.
● Medicines, including controlled drugs, were stored securely in locked cupboards with access restricted to staff. However, the practices in place to maintain and monitor the temperature at which medicines were stored did not suitably ensure medicines were consistently stored within the manufacturers' recommended temperature range so they would remain effective.
● The dosage instructions on medicines administration records (MARs) were not always clear. The provider had not taken appropriate action to clarify how these prescribed medicines should be administered. For example, there were no directions or records of where to apply people's prescribed topical medicines, such as creams.

● The provider's medicine policy did not reflect best practice and did not enable staff to support people to take their medicines safely. Staff did not follow the provider's medicines policy. Staff had made handwritten amendments to MARs without a second member of staff checking and endorsing these, in line with the policy.
● On 2 July we observed staff interrupt one person's lunch to encourage them to take some liquid medicine. The person was reluctant to have this while they were eating and wanted to drink the cup of tea they had instead. As a result, the person did not finish all of their liquid medicine.
● Some people were having their medicines given to them mixed with food. Staff said this was to help them swallow, but care plan records showed the prescriber considered this as covert administration. There were no records to show that covert administration was in the people's best interests, in line with the principles of the Mental Capacity Act 2005. There were no directions from a healthcare professional on whether it was safe to mix the medicines with food, as this can damage the coatings that can be found on some medicines. In May 2019 the local dispensing pharmacist had recently conducted a review of medicines support practices and had similarly found these covert administration arrangements should be recorded in more detail.
● Despite all the above the provider had not taken prompt action to address the issue of covert medicines. Pharmacists from the local Clinical Commissioning Group also conducted a review of medicines management shortly after our inspection visit. This also found issues regarding the arrangements to maintain and monitor medicines storage temperatures, information being available to staff regarding people's 'as required' medicines, and keeping covert administration arrangements up to date.
● We saw the provider carried out both daily checks and regular audits on medicines as outlined in the medicines policy, but it was not clear if this had always been the case since our last inspection. The daily checks had identified when there had been medicines administration errors and action was taken to address these. We saw there had been a number of administration errors since our last inspection which indicated that people did not always receive their medicines as prescribed.

This indicated the provider did not have an effective and robust system to manage medicines in a safe way. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The local dispensing pharmacist had recently conducted a review of the medicines support practices within and made recommendations for improvement.
● Staff had completed online medicines training and a manager from one of the provider's other services had recently assessed staff competency in medicines support.

Staffing and recruitment
● Required recruitment checks to make sure new staff were suitable for the role were not always completed.

● One support worker started work in May 2019 but recruitment records showed the provider only obtained a criminal records check for them from the Disclosure and Barring Service on the first day of our inspection visit. The manager could not demonstrate how the provider had ensured people were safe while the employee was working at the service and this check was outstanding.

This meant the provider had not always operated suitable recruitment procedures to ensure only 'fit and proper' staff worked at the home. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other staff records showed the provider had completed necessary pre-employment checks so they only

offered positions to appropriate applicants. These included detailing applicant's previous work history, gathering references from their previous employers and obtaining criminal records checks.
● There were staff vacancies at the time of our inspection and the provider engaged temporary support staff to cover these. The provider engaged the same temporary staff where possible so people were supported by people who they were familiar with. The provider was actively recruiting to fill the support staff and deputy manager vacancies.

At the inspection on 4 December 2018, we recommended the provider seek and follow best practice guidance on determining appropriate staffing levels to meet people's assessed needs. At the inspection on 2 July 2019 we found the provider had made some improvements by increasing staffing levels from two to three support staff working in the afternoons and evenings.
● People received the care and support they needed to be safe, but staff did not always have the time to be flexible to respond to people's needs in a timely manner.
● Support staff told us they were concerned there were still not enough staff to support people effectively. Their comments included, "We struggle to get some things done but it is better." Some people needed two staff to support them with personal care or to mobilise using hoists. If these people required support when the third member of staff supported someone else to go out, other people who required supervision at home had to wait for their care. Similarly, if two staff supported two people to go out leaving only one support worker at the home then people had to wait for their care. Support staff told us that if managers were present at these times they did not always help to provide care to people. We discussed this with the provider so they could review this practice.

Preventing and controlling infection
● The provider had prevention and control of infection arrangements in place but these were not always followed.
● On 3 July 2019 we found a film-wrapped packet of raw meat stored on top of film-wrapped cooked meat. This presented a risk of cross-contamination. We discussed this with the service manager and they took immediate action to remove it.
● Some areas of the home appeared clean but others areas had not been cleaned for some time. For example, there was dust on some bedroom lampshades and on skirting boards in a bathroom.
● Permanent staff had completed training in food handling and hygiene in the last year, but new staff had not benefited from this. This meant that not all staff had completed training so they could support people to prepare meals safely. The provider told us they were reviewing people's training and induction requirements.
● Managers were working with a local infection control professional who had visited the home recently to identify improvement actions needed to make sure people continued to be protected from the risk of infection. For example, replacing tiles and fixtures in the bathrooms, improving the general cleaning of the home environment and developing an infection control 'champion' position.
● We saw staff using equipment such as gloves, aprons and handwash to prevent and control infection. Staff said these were always available when they needed them.
● The provider arranged for water storage systems to be checked annually to make sure they were safe.

Systems and processes to safeguard people from the risk of abuse
● The provider had adult safeguarding systems in place but these were not fully embedded in the service. For example, not all the staff we spoke with had received training on adult safeguarding since they started. One support worker told us there had been no discussions around adult safeguarding to promote ongoing awareness. However, staff we spoke with knew how to recognise and respond to safeguarding concerns and felt they would be listened and responded to if they raised these.

● Managers had engaged in safeguarding processes led by the local commissioning authority to respond to safeguarding concerns.
● There was easy read information about adult safeguarding in people's support plan files, although it was not clear people using the service could understand this.

Learning lessons when things go wrong
● Records of incidents and accidents showed the actions staff had taken when these occurred. Managers had recorded actions taken and lessons learnt from analysing incidents to reduce the risk of the same incidents happening again. For example, updating a person's risk management plan with when there was an error administering a person's medicines or updating a person's risk management plan.
● The provider had responded to issues regarding staff performance following our last inspection and identified actions to address this.

Requires Improvement

Is the service effective?

Our findings

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

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

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

Staff support: induction, training, skills and experience

- Staff did not always receive training or learning opportunities to enable them to develop and maintain their skills to carry out the duties they were employed to perform.
- One member of staff told us, "I do not think I have done any training for a long time." Training records indicated some staff had completed training online which the provider had indicated was mandatory for staff to do. This was in areas such as health and safety, moving & handling and first aid. Some staff had not completed annual refreshers of this training, which was required by the provider's staff training policy. The records showed staff new to the service since our last inspection had not completed the mandatory training. The provider told us they were working with the staff team to update their training.
- The provider did not use day-to-day and periodic formal supervision to develop and motivate staff and review their competence, practice or behaviours. Staff told us they had not benefited from formal supervision sessions or meetings with a manager to discuss their performance and development. Managers told us staff supervisions had not been taking place recently and could not provide any records of supervisions during our inspection visits.
- On 2 July we observed the manager of the service speaking to a support worker to tell them they should read some support guidelines. To do this, the manager interrupted the staff member while they were trying to help someone to leave the room to provide them with personal care and required them to explain this was what they were doing. This was not an appropriate way to supervise the support worker while they were supporting someone.
- The provider did not always complete a comprehensive induction with new staff in line with the 'Care Certificate' to make sure they had the skills and competence to provide effective care. The Care Certificate provides an identified set of standards health and social care workers should adhere to in their work.
- There were no recorded inductions for two new staff who had joined the service since our last inspection. One new support worker told us they had shadowed other support staff for two weeks when they first started to learn how to support people, but they had not benefitted from any induction programme or training sessions to prepare them for their role. This also meant new staff had shadowed support staff who had not completed their required training. We discussed this with one of the provider's managers who was supporting the service to improve and they acknowledged the inductions for the new staff had not taken place and would have "to be re-started".

This meant provider did not make sure staff always had the skills and experience or support and supervision

needed to provide effective care and support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had attended two training sessions since our last inspection on safeguarding adults and how to communicate more effectively. Some staff told us they found this helpful for understanding how to communicate with people who used the service and improving communication within their team.
● Records indicated some staff had completed online training on a variety of topics, such as epilepsy awareness, dementia awareness and Deprivation of Liberty Safeguards. After the inspection the provider told us more staff training sessions were arranged for the months our visit.

Supporting people to eat and drink enough to maintain a balanced diet
● On 2 July 2019, 3 July 2019 and 5 July we found there was not an organised approach to make sure people were always supported to eat food that met their dietary requirements and reflected their preferences.
● Staff told us there were no menu plans in place and there was not a planned approach to buying food for or with people that reflected their preferences. Some staff said weekly shopping was organised by the provider but other staff were not clear how and said they went out each day to buy food instead. It was not clear how people were involved in choosing what they ate during the day. On 2 July 2019 staff did not give people choices of what to eat and drink for lunch.
● Records of daily care were completed for most mealtimes in the month before our inspection to show what people ate and drank. These showed some variety in the meals some people ate, but this was not always the case. For example, daily records for one person in the month before our visit showed they had eaten soup for lunch on 15 occasions. There was no record of the person choosing this, no record in their support plan of them favouring soup, and their safe eating support guidance did not say they should only have food in a pureed or liquidised form.
● We found there was very little fresh vegetables or fruit in the kitchen. One member of staff told us the home did not often have fresh vegetables or fruit in stock. One person's relative told us they did not think there was a problem with people's food there but stated, "I used to see a lot of fruits around but not now". They told us that in the past some staff used to make people fruit smoothies to drink, but they did not think this was happening any more.

The above meant the provider did not always have regard to people's well-being and quality of life when meeting people's nutritional and hydration needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider informed us there were four-weekly menus in place based on some people's expressed or known likes and dislikes, but these were not used on the days of our visits.
●The provider informed us their central office ordered weekly food shopping deliveries online, based on shopping lists the home provided and we saw evidence of these shopping lists. The provider was in the process of changing this so staff at the home could order the shopping, based on discussions with people who could communicate what they wanted or on the preferences and likes and dislikes for those who could not communicate. Daily records of care indicated these discussions sometimes took place with some people, but it was not clear if what was bought reflected people's preferences.
● People were supported to have enough to drink. We observed people being offered drinks regularly throughout their day and there were records of this taking place as well.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The service did not always share information in a timely manner with relevant professionals to make sure

people's health and wellbeing was maintained or improved.
● On 3 July 2019 we saw records showing one person who lives with epilepsy experienced a series of seizures in one day in the month before our visit. Their epilepsy support plans indicated this was not their normal experience of epilepsy. Staff supported the person to hospital and then their GP, but there was no record of the service informing specialist learning disability and epilepsy healthcare professionals who worked with the service of this incident. We notified the manager of this so they could take action to address this, which they said they would do. However, two weeks after our visits healthcare professionals confirmed they had not been informed of this important information as they require of the service so they could monitor and review the person's health.
● In general, staff supported people to access healthcare services and to have their health needs met. This included support to attend annual health checks and appointments with consultants, nurses and their GP. Staff recorded the outcomes of these appointments and shared this information with the team.
● Staff worked together with one person's relative to support them to attend medical appointments.
● People had health actions plans in place and these provided information about people's healthcare needs, the healthcare professionals involved and how these needs were to be met.

Adapting service, design, decoration to meet people's needs
● The provider had made some improvements to the environment since the last inspection in December 2018. These included repairing the flooring in the main corridor and the sensory room, adding a safety restrictor to the large window on the staircase, clearing out the upstairs office environment. Some communal areas had been re-painted and there was new furniture in the communal lounge. On 5 July 2019 the provider started moving the office equipment from upstairs to a spare room downstairs. Managers told us this was so they could be more accessible to people and staff.
● Further repairs and decoration were required in other areas of the home. For example, in the accessible bathrooms some of the floor was damaged or caused water to pool there after people's showers rather than drain away promptly. Hand soap dispensers also appeared to have been broken for some time and the paintwork on the walls, door frames and wooden toilet roll holders appeared chipped and worn. One member of staff told us they appreciated the new paintwork but stated people's bedrooms also needed redecorating.
● On 2 July 2019 we saw people's bedroom doors did not have any decorations or personalising features on them. There were peeling contents labels stuck to some people drawers and cupboards in their rooms. These appeared to be for the benefit of staff and did not appear to promote a homely environment.
● The provider had recently cut the grass in the back garden so people could be supported to access it. There were table and chairs outside, but no other features. The manager told us they planned purchase a gazebo for people to use for shade and to develop a sensory garden area for people to use.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection we found some people's rights were not being respected as they were not being supported in line with the principles of the MCA. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.
At this inspection we found enough improvement had been made and the provider was no longer in breach of Regulation 13.

● In the support planning records we checked, we saw the provider had been working with a relevant local authority to review or confirm authorisation of people's care arrangements where the authority had previously assessed people lacked the capacity to agree to those arrangements and they amounted to a deprivation of their liberty. We saw the new manager follow this up with the authority during our inspection visits.
● Training records indicated staff employed by the provider had completed awareness training on the MCA and DoLS.
● We saw some staff giving people choices about their care during their day-to-day living and respecting their decisions, such as where they wanted to sit and how they wanted to be supported to use their wheelchair.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider was not assessing people to move into the home at the time of our inspection.
● People had been using the service for a number of years and periodic reviews of their care and support needs informed their support and risk management plans. These plans considered different areas of people's daily living such as their daily routine, personal care and physical health.
● People's plans contained a limited amount of information about what people liked and disliked, such as their food preferences.
● The provider had recently begun working with an adult social care professional to develop positive behaviour support plans to better understand and support a person whose behaviour may sometimes challenge others. The professional told us that staff were engaging constructively in the early stages of this process.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same, inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
At the inspection on 4 December 2018, we found the staff did not always treat people with kindness and in a way that promoted people's dignity. At the inspection of 2 July 2019, we found this was still the case. This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 10.

● We witnessed staff interacting with people in a way that did not treat people with dignity and respect and did not always demonstrate empathy for people using the service.
● On 2 July 2019 we witnessed a member of staff interrupt a person while they were eating their lunch to try to administer their prescribed medicines to them. They were sat at the dining table with other people and staff at the time. The support worker's attempts to persuade the person included talking to them in front of the other people about a health issue and going to the toilet.
● On 2 July 2019 we observed staff supporting people without explaining what they were doing or why. For example, we saw staff placing aprons around people's necks and fronts without talking with them about this.
● On 2 July 2019 we witnessed staff supporting another person while they were eating soup. During this time staff used a piece of kitchen paper towel to wipe the dining table and then used the same paper towel to wipe the person's face. When the person had finished their soup, staff then used the clothes protector the person was wearing to wipe the person's face. No one was offered anything more appropriate to wipe their faces or hands.
● On 2 July 2019 we observed staff supporting a person who had refused a tuna sandwich for lunch. A support worker then buttered another slice of bread on the table, not using a plate. They added jam to this, folded it in half and gave it to the person. Staff Member N had not washed or wiped their hands between the tuna and jam spreading so the flavours were not mixed.
● The provider did not ensure people's independence was always promoted.
● Some people's support plans set out how to promote a person's independence while providing their care and support. For example, using hand-over-hand guidance to support someone to wash themselves. Daily

records of care did not indicate this was happening. The daily record form required support staff to note what a person had done independently that day. However, records we reviewed for the month before our visit often did not record anything for this or only noted that a person fed themselves, or that they rolled over in bed while being supported to get up.

● A recent monitoring visit by the local commissioning authority had also identified that the support planning system was designed to support people's independence but the provider had not always ensured this was put into practice.

The above shows people were not always treated with dignity or respect and their independence was not always promoted. This was a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We also saw instances of some support staff talking with people in a respectful way, offering choices and acting in a gentle and caring manner. For example, we saw two staff using a hoist to support a person to move between chairs in an unhurried manner while providing lots of calm and reassuring support to the person. A member of staff told us they thought staff "now have more respect" for the people and a relative told us they thought staff were talking to people more than they used to. An adult social care professional told us they had seen staff acting with people politely and with respect.

● People's support plans provided guidance on how to promote people's dignity while providing personal care. An adult social care professional told us they had observed staff providing good personal care.

● People's support plans noted relationships that were important to people and how people kept in touch with friends or family.

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

● People were not always involved in their care and support in a meaningful way.

● On 2 July 2019 we observed a person saying they wanted to use the toilet and staff told them they couldn't as they had to wait for an assessment from another adult social care professional. This did not appear as an appropriate way of explaining to the person how they could not be supported to access the toilet while new mobility equipment was required to help them to do that safely.

● The provider informed us staff met with people weekly and monthly to discuss food choices and the service. However, we could not find records of recent meetings during our inspection. We saw records of staff changes and Christmas celebration arrangements were discussed with people at a meeting in late 2018.

● Relatives told us they felt involved in people's support planning and staff gave them information and support to contribute to this. One relative told us, "I am always involved in what they are doing."

● People's support plans described how people would express decisions about their care and support during the day. For example, how a person declined a choice of clothing suggested to them. We saw staff responding to people's immediate choices and refusals of support during our visit, such declining food that was offered.

Requires Improvement

Is the service responsive?

Our findings

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

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

This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
At our last inspection the provider we found the provider did not ensure that people always received care and treatment which was appropriate, met their needs or reflected their preferences. This was a further breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of Regulation 9.

● The provider did not ensure that people regularly participated in meaningful activities which offered stimulation or met their individual interests while they were at home. This meant the service did not support people to have a good and meaningful everyday life and people were not receiving care that was personalised for them to meet their assessed needs and preferences.
● One adult social care professional told us they did not think people were supported with many activities during the day, "[The people] seem to spend a lot of time in the living room not doing much." A recent monitoring visit by the local commissioning authority had also identified that staff did not actively engage with the people in suitable activities.
● On 2 July 2019 and on 5 July 2019 we observed people being supported to sit for periods of time before and after lunch in the lounge with a music television channel on. Staff only spoke with people intermittently to ask if they were ok and to offer them a drink.
● On the afternoon of 2 July 2019 we saw a person who had a tendency to move around the home throughout the day walk independently into the garden on several occasions. We saw staff telling the person to come back inside, saying it was too hot outside and they had already been out that day. This meant the person was not always able to take advantage of opportunities to do things at home that were meaningful to them.
● On 2 July 2019 we saw assorted games and other activities equipment stored in the lounge, but only observed staff collect some art material and paper. This was placed on a small table near one person and left there. Occasionally staff spoke with the person about the art materials but no one helped the person to pick up or use them.
● Daily records of care showed when people stayed at home, the only activity provided regularly to them during the day was sitting in the lounge with the television or some music on. On some occasions, some people's only recorded activity in the morning or afternoon was cleaning their room.
● People were still not supported to regularly access their local community. For example, people's 'social events records' showed one person only went out in the community twice in the month before our visit and

only once the month before that. Another person went out once in the month before our visit and twice the month before that.
● The service had a vehicle that was accessible for people using wheelchairs. Staff told us they had not been able to use this for several weeks due to a fault. This meant at the time of the inspection people had less opportunities to access their community.

The above shows the provider did not ensure that people always received care and treatment which was appropriate, met their needs or reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person's relative told us support staff had recently sent them pictures of the person. They commented, "I thought that was so nice. If I can't go there for a couple of weeks, it's nice to get pictures." They told us the service had never sent them pictures like this before.
● There was a long-standing arrangement when members of the community known to the service visited to hold religious and other story-telling sessions with people. We saw this took place on a weekly basis and staff told us people enjoyed it.
● A person's relative told us another agency visited with some animals to entertain people earlier in the year.
● Everyone had recently been supported to go out for a meal together at the local pub. We were told one staff member remarked that people have never been supported to do this before.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's support plans gave descriptions of how staff should support people when providing them with personal care, such as washing and dressing. These included how to involve a person in this care and how they may make choices during their care, and whether they preferred to be supported by male or female staff.
● While people's support plans described how staff should provide personal care, plans did not give information and guidance on how to interact with people and engage them in meaningful activities. Some staff told us some of their team, when not providing people with support to wash, dress and eat, did not sit and interact with people and provide them with stimulation. This meant some people did not always receive planned care and support to enage them in meaningful interactions with others.
● People's support plans identified goals to support people to achieve. These included going on holiday, going out more and accessing more activities. There was a lack of evidence to show people had been supported to achieve these things. This meant people were not always supported to achieve and take part in new activities that were meaningful to them.
● Some of the current support and risk management plans we viewed were overdue a review. We saw managers were in the process of updating these to make sure they better reflected people's needs and the care and support required to meet those needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● At the inspection on 4 December 2018 we found information in people's support plans on how individuals communicated their preferences and choices, but there had been no planned approaches for how staff

should communicate positively with people. At the inspection on 2 July 2019 we found this was still the case.

● The provider had not fully implemented the AIS to meet people's communication needs.

● One person's support plan stated they tended to talk frequently about subjects that were important to them. There was no guidance on how staff should respond positively, sensitively and consistently to the person at these times.

● Another person's support plan set out some Makaton signs they were known to use. Makaton is a form of sign language designed to support spoken communication. We did not see any staff using Makaton when they communicated with this person or anyone else. Training records did not show staff had completed any Makaton training to help them communicate with this person.

● On 2 July 2019 we did not see observe staff using techniques such as appropriate touch, objects of reference or any other forms of positive communication to engage people.

● Staff had recently attended training on how to communicate with people who used the service, which staff said was helpful.

Improving care quality in response to complaints or concerns

At the inspection on 4 December 2018, we recommended the provider review their complaints procedure in line with current published guidance on raising complaints about adult social care services. At the inspection on 2 July 2019 we found the provider had made some changes but these were not enough.

● The complaints procedure we saw still advised complainants to refer their complaint on to the CQC if they were not happy with the provider's resolution, rather than to the local authority which funded people's care and the Local Government Ombudsman. However, the provider also indicated it was in the process of reviewing their complaints policy and procedure.

● There was easy read information about the complaints process available, although it was not clear people using the service could understand and use this.

● There had not been any formal recorded complaints at the service since our last inspection.

End of life care and support

● No one was receiving end of life care at the time of our inspection.

● People's care plans indicated potential end of life care needs had been considered and they had been supported to develop f plans for the future.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same, inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found the provider's audit systems for monitoring the quality and safety of the service were not operated effectively because the systems had not effectively assessed the quality of care, activities and staff interactions that people were experiencing at home. The provider's management team had also not been effective because they had failed to identify the concerns that existed at the service and had therefore not been able to make improvements. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17.

● At the inspection in December 2018 we found the service to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We met with the provider, took enforcement action to require the provider to make improvements and they sent us an action plan telling us how they would do this. At this inspection we found four ongoing breaches and two new breaches of regulations.
● The systems and processes to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service had not been operated effectively. For example, action had not been taken to provide training for staff regarding the risk of choking when this had been had already been identified and corrective action was not taken to address elevated water temperatures.
● People were not always being treated with dignity and respect or being supported to experience good and meaningful everyday lives. The provider had failed to make sufficient improvements in these areas.
● The systems and processes had not ensured safe recruitment practices were always used to employ new staff, new staff did not benefit from structured inductions to the service and staff were not consistently supported to provide effective care through training and supervision opportunities.
● We could not see evidence of staff team meetings taking place regularly since our last inspection so staff received the support they needed and team-working could develop.
● The provider did not always keep accurate, complete and up to date records of people's care and treatment.
● Staff used forms to record what and how much people drank during the day. However, the records were

not completed consistently and there was no calculation of the total amount people drank each day. This monitoring of people's daily fluid intake was not included in their support and risk management plans and it was not clear why this was required. It was also not clear what action staff should take and when and if the records showed a person had not drunk enough.

● The local commissioning authority's recent monitoring visit had identified a person's dysphagia assessment recommended staff kept a record of the person coughing, wheezing and experiencing watery eyes. The audit found an undated record form for this with no entries.

● Daily records of care were not always completed. On some days there was no record of the care provided such as what a person did during a morning or afternoon, what they ate for their meals and if the person had indicated unhappiness or behaviours that some may find challenging. Sometimes there was no record of whether a person had been supported to clean their teeth in both the morning or evening.

● The culture of the service did not consistently assure the delivery of high-quality care.

● Staff told us there was often a negative atmosphere in the staff team and they team did not communicate well with each other. Some staff said they were not supported to work well together while others said they appreciated managers were trying to improve this. An adult social care professional told us they thought the culture had improved recently stating, "the culture of the staff was not particularly nice, however over the past few months there has been a change for the better."

● Some staff said they had not always felt supported in their roles by senior staff or the organisation.

● There was a lack of leadership on a day to day basis. This meant people's care and support was not always well organised. One support worker told us, "There is no guidance or direction – we do not know whose job is whose and what we are supposed to be doing." Staff did not always complete a plan for their shifts to help arrange people's care and activities. For example, some staff did not know what the food shopping arrangements were. Some staff did not know the home's vehicle was not working until they tried to use it. We saw that the provider had identified shift planning and organisation as an improvement issue.

This meant the systems to assess, monitor and improve the quality and safety of the service had not been sufficiently robust to have identified or taken timely action on the areas for improvement we identified. The provider had also not made sure accurate, complete and contemporaneous records of people's care and support were consistently maintained. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found the provider had not conspicuously displayed on their website the last performance rating the CQC had awarded to this registered care service. This is required by law. At this inspection we found the organisation's website still did not provide display a rating for this service and still provided a link to an old 2017 CQC inspection report. The CQC is still considering what action it needs to take in relation to this matter.

● The manager and a visiting adult social care professional informed us the local commissioning authority had convened a safeguarding adults meeting regarding a person not receiving their medicines as prescribed. The provider had not notified the CQC of this allegation of abuse as it is legally required to do. The CQC is still considering what action it needs to take in relation to this matter.

● Managers conducted periodic quality audits of the service. These included reviewing the medicines administration records, health and safety checks and checking of the money held on behalf of people.

● There was no registered manager in post when we inspected. The new manager had recently started working for the provider and they told us they were in the process of applying to register with the CQC at the time of the inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The managers could not provide us with a current action plan setting out the actions the provider had taken and was planning to take to improve the service. However, we saw a draft version of a new plan the managers were developing. This set out improvement actions to be taken, such as staff recruitment, training and supervision and decorating people's rooms.
● Incident records detailed actions taken in responses to issues, such as errors with people's medicines.
● A relative told us they had met with senior managers and one of the provider's board members to discuss the improvements required at the service following our last inspection.
● We saw that when mistakes had been made, such as errors administering people's medicines, these were acknowledged and addressed. This included apologising to the person involved.
● One relative told us there had been some improvements at the home, such as the new flooring and some decorating. However, they also said, "There are a few changes, but I still don't think it is enough. They keep saying they're going to be doing this and that and then it doesn't happen."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● One person's relative told us they felt involved in their family member's care and support.
● Some staff told they were able to discuss issues with the previous service manager and felt listened to. They said they felt they could speak to the new service manager as well.
● The provider had not conducted any more stakeholder or feedback surveys since our last inspection.

Working in partnership with others
● The service worked with healthcare and adult social care services. Professionals from these agencies told us staff usually shared information when required although sometimes the recording of information, such as details about people's epilepsy seizures, had not been consistent and not readily available when required. This meant information sharing with other agencies to promote joined up care for people was not always consistent.
● The provider was working with healthcare and adult social care professionals to address improvement issues at the service, such as the local commissioning authority, the statutory behavioural support team and a local infection control professional.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that service users received care and treatment which was appropriate, met their needs or reflected their preferences. Regulation 9(1)

The enforcement action we took:

NoP to vary condition of registration to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

NoP to vary condition of registration to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users because they did not always: : Assess the risks to the health and safety of service users receiving care : Do all that was reasonably practicable to mitigate such risks : Ensure the safe and proper management of medicines – TBC with MET report Regulation 12(1) and (2)(a), (b) and (g)

The enforcement action we took:

NoP to vary condition of registration to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity Regulation 17(1)(2)(d)

The enforcement action we took:

NoP to vary condition of registration to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always operate effective recruitment procedures to ensure that it only employed 'fit and proper' staff to provide the regulated activity. Regulation 19(1)(2

The enforcement action we took:

NoP to vary condition of registration to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff employed by the service in the provision of the regulated activity received appropriate training and professional development as is necessary to enable them to carry out the duties they are employed to perform Regulation 18(2)(a)

The enforcement action we took:

NoP to vary condition of registration to remove location