Life Opportunities Trust

Life Opportunities Trust - 329 Martindale Road

Inspection report

329 Martindale Road
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Life Opportunities Trust - 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 four people were living at the home. People had their own bedrooms. They shared the kitchen, dining room, living room, laundry facilities, a 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 provider had made some improvements to how the service was managed and the care people experienced. These included staff treating people in a more attentive manner, improved medicines support, the home environment, safe staff recruitment and staff support.

However, a number of improvements were still required. People were not always treated with dignity or respect. People's support and risk management plans did not set out how to avoid people experiencing the risk of skin damage and discomfort. People did not always receive personalised support to help them regularly enjoy in activities that were meaningful to them. People did not always experience a planned approach to meet their communication needs.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support. This is because people were sometimes not treated with dignity and respect. People did not always receive person-centred support that helped them to have good, meaningful everyday lives.

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 and in their best interests; the policies and systems in the service did not support this practice.

The provider's arrangements to monitor the quality of the service and identify and take action when improvements were required not been operated effectively. While there had been some improvements, the

provider had not addressed the ongoing issues we found at this inspection.

Safe staff recruitment procedures made sure only suitable staff were recruited to work at the service. Staff leadership, support and supervision had improved. Staff were inducted to the service, completed a range of training and felt supported by the organisation.

People were supported to be healthy and to access healthcare services. People received their medicines and as prescribed.

People were supported to eat and drink appropriately. There was an organised approach to providing food for people to ensure they received a variety of appropriate meals.

The home was clean and well-maintained. The provider had continued to make improvements to the home environment, including redecorating bathrooms and communal areas and purchasing new furniture. Most people's bedrooms were personalised.

People's support and risk management plans described how to meet their care needs. Plans included some personalised 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

Rating at last inspection and update
The last rating for this service was inadequate (published 23 August 2019) and there were multiple breaches of regulations. 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. This service has been in 'special measures' since 31 January 2019. Following the last inspection we took action against the provider in respect of the breaches we identified. We have not yet published details of this action.

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

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

Enforcement
We have identified four 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; managing risks to people's safety; and having effective systems in place to monitor the quality of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Special Measures

The overall rating for this service is 'Requires improvement'. However, we are continuing to place the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always 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 conducted the inspection on the first day and one inspector attended on the second day.

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. The provider informed us this person would apply to be the registered manager. However, we had not received an application 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
During the inspection we met all four people who lived at the service. The people had complex needs and could not describe to us how they felt about living at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three temporary support workers, two support workers, the deputy manager and a peripatetic service manager. We looked at the care and risk management plans for four people, medicines support records, and a variety of records relating to staffing and the management of the service.

After the inspection
We spoke with two relatives of people who lived at the service and seven health and adult social care professionals who have worked with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to 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 inspection in July 2019 the provider had failed to robustly assess and manage 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 we found some improvements had been made but the provider was still in breach of regulation 12.

● At the last inspection adult social care professionals said they had advised the provider people who used wheelchairs and hoists with slings to mobilise needed to change position every four hours to avoid the risk of skin damage and discomfort. People's care and risk management plans had not set out people needed to change position this regularly. At this inspection we found people's plans still did not state this. Records of people's daily care did not indicate staff supported them to change position regularly.

Although we found no evidence people had been harmed, this 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 continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's risk management plans identified other areas of risk to people's safety and the actions required to minimise those risks. The areas included living with epilepsy, bathing support and accessing the home's vehicle.
● At the last inspection staff had not accessed training on how to use people's new slings to help them transfer between beds and chairs using hoists. At this inspection we saw staff had completed this training so they could support people to transfer safely. We also observed staff safely support a person to transfer from one chair to another using a hoist and their sling.
● Previously, we had found the provider identified staff needed training on supporting people living with dysphagia (having difficulty swallowing) to reduce risks of choking, but this had not taken place. On this visit we found staff had received this training. Adult social care professionals also confirmed this and said staff engaged constructively in the training. Up to date support guidance described food textures for staff to follow when they prepared people's food. This demonstrated the provider had taken reasonable steps to protect people from the risks associated with swallowing difficulties.
● Staff checked water temperatures around the home each week to make sure water was not too hot for people's bathing. At the last inspection checks showed a bathroom's shower water was too hot for people to use safely and no recorded action had been taken to address this. At this inspection we saw these checks consistently indicated water ran at safe temperatures for people to use.

● The provider conducted regular checks to make sure people were safe. These included checking the home environment was clean and safe, ensuring the first aid box was appropriately stocked and maintenance issues were being addressed. Staff checked people's mobility equipment was clean and safe to use. However, one relative expressed frustration at the time being taken to arrange for a person's wheelchair to be replaced so they could access the community safely.
● There were fire safety arrangements in place. These included individual evacuation plans for people which we saw on display in people's bedrooms. However, there was a discrepancy between these plans and the fire safety measures set out in people's individual risk management plans. We notified the manager so they could address this.
● We saw the provider had reviewed the fire safety assessment for the service and records showed staff practiced evacuations during the day or the evening regularly. Staff had completed mandatory fire safety training so they knew how to support people safely 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 enough improvement had been made and the provider was no longer in breach of regulation 12 in relation to the safe management of medicines.

● People's medicines were stored securely in lockable, clean cabinets in their rooms bedrooms. Staff monitored the temperatures of the cabinets and the amounts of medicine being held. However, we found a device staff used the crush a tablet for one person was not clean as it contained a small amount of residual tablet powder in it. This created a risk of incorrect dosage due to a potential build-up of medicine powder.
● People's support plans and medicines administrations records (MARs) provided clear information about their prescribed medicines and how to safely support people with these. We noted MARs were loose and not bound in people's medicine support folders. This meant MARs may not always be kept ordered in such a way as to reduce the risk of errors. However, we saw the managers had recently introduced a new system whereby a second member of staff recorded they had observed medicines being administered appropriately. Staff had completed MARs appropriately.
● People were prescribed medicines to be taken only 'when required', such as for pain relief or in an emergency. There was guidance for staff on when to support people to take these medicines. We saw the managers had asked the prescriber for clarification on this when such medicine had been dispensed without clear direction. This helped to ensure people received their medicines as prescribed.
● Staff supported a person to take some medicine mixed with food. At our last inspection we found there were no records to show this covert administration was in a person's best interests, in line with the principles of the Mental Capacity Act 2005 (MCA). At this inspection we saw the manager had met with healthcare professionals and the person's relative, to determine support this was in a person's best interests as they lacked the mental capacity to agree to this. The manager had sought confirmation from healthcare professionals that it was safe to mix the medicine with food.
● Training records indicated all staff had completed online medicines support training. Where staff provided medicines support, managers had assessed their competency do so.
● The provider completed regular checks on medicines. These checks had identified when there had been medicines support errors and managers had taken action address these.

Staffing and recruitment
At our last inspection 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. Enough

improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The provider had recruited two staff since our last inspection. Recruitment records showed the provider had completed the necessary checks to make sure they offered the roles to fit and proper applicants. This included obtaining criminal records checks before people started working at the service.
● At the time of our last inspection there were staff vacancies and the provider engaged temporary support staff to cover these. At this inspection we found this was still the case. We saw the provider engaged the same temporary staff where possible so people were supported by staff who they were familiar with and who knew how to meet their care needs.
● There were enough staff to meet people's care needs safely and to support people and to participate in some a small number outstanding activities. The provider had maintained a staffing level of three staff working in the mornings and evenings to support the four people. Staff told us this was an improvement as they had enough time to meet people's care needs and support them to engage in activities and go out more often than previously.

Systems and processes to safeguard people from the risk of abuse
● Some people had experienced an inconsistent approach to safeguarding them from avoidable harm which meant the provider had not always protected them from risks to their well-being and safety. Since our last inspection the local commissioning authority had investigated concerns about a person's care as a safeguarding concern. Managers had worked with other professionals to respond to this.
● The provider had systems in place to protect people from abuse. These included processes for recording and monitoring when staff handled people's money so as to protect people from the risk of financial harm.
● Staff had completed training on safeguarding adults. Staff we spoke with knew how to respond to safeguarding concerns and felt they would be listened to if they raised these. Staff also knew about whistleblowing and that they could report such concerns to other agencies if required. There was information about adult safeguarding on display in the home and records showed managers discussed this at team meetings to promote staff awareness.

Preventing and controlling infection
● When we visited on 20 January 2020 a large bin outside the home was overflowing with rubbish bags which created a risk of the premises not being kept clean and hygienic for people and staff. We saw the deputy manager had been working with external contractors to resolve this.
● At our last inspection we found there were arrangements for the prevention and control of infection but these were not always followed. At this inspection we found these were being followed. This included making sure food was appropriately wrapped and labelled when it was opened and stored in the fridge to avoid the risk of cross-contamination.
● Staff had completed safe food handling and infection control training so they could promote support people safely. We saw staff were also due to attend additional food safety training in the month after our visit.
● People's rooms, bathrooms, corridors and communal areas appeared clean and this helped to promote infection control.
● Staff used equipment such as gloves, aprons, handwash and hair nets when cooking to prevent and control infection. The team monitored and re-ordered stocks of these to make sure they were available when staff needed them.

Learning lessons when things go wrong
● The provider had systems in place to record and monitor incidents and accidents.
● Managers recorded when incidents occurred and the actions taken in response to these. We saw action

was also taken to lessen the risk of the same incident happening again. For example, after a medicines administration error managers then required a second member of staff to observe medicines being administered so as to reduce the risk of errors re-occurring.

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
At our inspection in July 2019 the provider had failed to 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. At this inspection we found some improvements had been made and the provider was no longer in breach of regulation 18.

● At the last inspection we found the provider did not use periodic formal supervision and day- supervision to develop and motivate staff and review their competence, practice or behaviours. At this inspection we found managers had recently re-instated formal supervision sessions with both temporary and employed staff. These included discussions about staff support and performance, team-working and people's well-being. Staff told us they found these sessions helpful.
● Managers provided more day-to-day oversight and support to staff and staff said they felt more supported by them. One told us, "As staff we feel like we are really helped." Another support worker said the provider's senior staff had supported them, "[The senior manager] comes to the house many times, doing lots of things to help out and explain what is needed, how to do it."
● At the last inspection we found some staff had not completed annual refreshers of some training as required by the provider's staff training policy. At this inspection we found this to still be the case, but we saw a range of face-to-face refresher training had been arranged for staff in the month after our visit.
● Staff records showed both temporary and employed staff had completed a variety of online and face-to-face training since our last inspection to enable them to develop and maintain their skills. This this included topics such as moving and handling, food safety, adult safeguarding, dementia awareness, data protection, person-centred care, and safe medicines handling.
● New staff received an induction to the service when they started, which included training, reading people's care and risk management plans and shadowing staff more experienced at working in the home. The provider had only employed experienced adult social care workers since our last inspection so we could not judge whether improvements had been made regarding the induction of new care staff in line with the 'Care Certificate.' The Care Certificate provides an identified set of standards health and social care workers should adhere to in their work.

Supporting people to eat and drink enough to maintain a balanced diet
At the inspection in July 2019 we found the provider did not always have regard to people's well-being and quality of life when meeting their 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. At this

inspection we found the provider had made enough improvement in relation to having regard to people's well-being when meeting their nutritional and hydration needs, although we found other concerns that continued to be a breach of regulation 9 (see Is the service Responsive?)

● At our last inspection we found there was not an organised approach for ensuring people were always supported to eat food that met their dietary requirements and reflected their preferences. At this inspection we found there was a more structured approach to ensuring people had enough to eat and drink enough and maintained a balanced diet.
● At our last inspection we found there was very little fresh vegetables or fruit at the home. At this visit we saw the kitchen had sufficient stocks of food, including fresh vegetables or fruit.
● There was a weekly menu plan in place that set out varied meals prepared daily by staff. Staff had completed records of daily care for all the mealtimes in the month before our inspection to show what people ate and drank. These showed people ate a variety of meals and these changed each day. One relative told us they felt staff followed the menu plans and said, "They have the meal chart, I see them [follow] it when I go there unannounced."
● At lunchtime we saw staff created a pleasant dining experience for people. This included supporting people in a relaxed and unhurried manner, encouraging people to eat independently and speaking with them about the smells and tastes of the food.
● On a couple of occasions, these records of daily care indicated when a person had been offered and made a choice of meal. We also observed staff offer each person a choice of drinks at lunchtime and drinks throughout the day to help them stay hydrated.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● At our last inspection we found the service had not always shared information with relevant professionals in a timely manner to make sure people's health and wellbeing was maintained or improved. At this inspection we found this had improved. Adult health and social care professionals' comments included, "[Before] it was very bad, they couldn't share information. [This] time they could share information about everything I could ask for" and "[Staff are] better at a handover of what's happened with people and reports on how people have been."
● Staff supported people to access healthcare services so as to meet their health needs. This included support to see their GP, chiropodist and consultants, dentists, and community nursing. Staff recorded the outcomes of these appointments and shared this information with the team. For example, we saw managers discussed advice from healthcare professionals in team meetings.
● Staff continued to support a person to attend medical appointments with their relative.
● 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 improvements and adaptations to the home environment since our inspection in July 2019. However, some of the adaptations and how staff supported people to use them did not appear to always meet people's needs. The provider had developed a new sensory room for people to use with tactile, sensory features on two walls for people to feel and play with. On 20 January 2020 we saw wooden chairs were placed in front of these features so they were inaccessible to three people who used wheelchairs to mobilise.
● There was a large noticeboard in the communal dining area. This showed assorted information for people and staff, including pictures of the meals planned for that day. We found one of the meal pictures was obscured by a party celebration pinned over it.

● Improvements to the environment included redecorating and repairing the accessible bathrooms, redecorating people's bedrooms and new furniture in the communal dining area. There was new furniture and some personalising features such as pictures on the walls in most people's bedrooms. A relative said they were happy with the changes. Staff and adult social care professionals told us they felt the environment was lighter and more welcoming. We saw the home was clean, well-lit and free from unpleasant odours. The provider had arranged for a contractor to complete a monthly 'deep clean' of the home to help maintain this.

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.

● People were being supported in line with the principles of the MCA. The provider worked with the local commissioning authority to review people's care arrangements where the authority had assessed people lacked the mental capacity to agree to those arrangements and they deprived people of their liberty.
● The manager had also assessed people's capacity to consent to elements of their care that may be restrictive on their liberty in their best interests so as to keep them safe. For example, using a lap strap on their wheelchair or side rails on their bed.
● Training records showed temporary and employed staff had completed awareness training on the MCA and DoLS. Some staff we spoke with, though, were not clear about what the MCA was. However, staff could explain how they supported people to make decisions about their care during the day, such as where they wanted to eat their meal. We also saw staff were also due to attend additional MCA awareness training in the month after our visit.

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 when we visited and no one had moved in since our last inspection.
● People had lived at the service for a number of years and their care needs were set out in support and risk management plans and the provider had reviewed these since our last inspection. These plans had some minimal information about things people liked to do, but there was little direction on how to support people to participate in regular, varied and meaningful activities at home or in the community. This meant assessments and reviews of people's needs and their plans did not always consider the full range of people's diverse needs.
● People's plans considered different areas of their daily living, such as daily routines, personal care and physical health needs, and things it was important for staff to know. For example, if the person lived with

epilepsy. People's plans provided some details about what people liked and disliked, such as their food preferences, and how to meet people's personal care needs, for example, when bathing or eating.

● The provider had been working with the local statutory authority's positive behaviour support team to develop planned approaches to support people whose behaviours may sometimes challenge others. We saw behaviour support plans were in place for two people and these had been developed based on understanding what people's behaviours may mean for them, in line with good practice guidance. Adult social care professionals told us managers and staff had engaged positively in this assessment, planning and support process and staff had worked to implement the plans consistently.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
At the inspection in July 2019, we found the staff did not always treat people with kindness and in a way that promoted people's dignity. 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 some improvements had been made but the provider was still in breach of regulation 10.

● At our inspection in July 2019 we observed staff supporting people without explaining what they were doing or why. We also observed this at this inspection. For example, we saw staff move people in their wheelchairs without always telling them what was happening or why. On one occasion we saw staff access an apron from the back of a person's wheelchair without explaining what they were doing as the person attempted to see who was behind them.
● We observed staff support a person to go to the sensory room. The person was then left in the room where they could not access the tactile features on the walls. They had nothing else to hold and picked out pieces of foam from the damaged arm of their wheelchair.
● We saw guidelines for staff on how to support people were posted on the walls in some people's bedrooms, which did not promote people's dignity and privacy.
● We observed staff addressing some people with a variety of informal variations of their names. While this appeared to be done with some affection, it was not clear people were able consent to this and these terms were not described as people's preferred names in their support plans.

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

● A recent monitoring visit by the local commissioning authority had also identified an instance when staff had not closed a person's bedroom door while they provided care to the person. We saw managers had taken action to address this when it was reported to them.
● We also saw instances of staff treating people with respect and promoting their dignity. For example, staff asked people if they could help them to put on aprons when eating and talked to people about how they were supporting them when using a hoist to mobilise.
● Other people told us staff they had seen staff treat people in a respectful manner. A relative said they felt staff were caring and described them as being "Much more attentive" to their family member. Adult social

care professionals told us, "Staff do appear to be genuinely caring" and "I have no concerns about [staff] being polite or caring." The manager had recently appointed a member of staff as 'dignity champion'. This support worker explained their role was to promote treating people with dignity and respect and support colleagues to do this.

● We observed staff supporting some people to be independent. For example, staff now encouraged one person to propel their own wheelchair around the home rather than doing this for them. Staff regularly encouraged another person to bring items such as their plates and cups to and from the kitchen. Some people used adapted plates and cutlery so they could feed themselves with minimal staff support.

● People's support plans continued to describe the friends and family relationships important to people and how people kept in touch with them.

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

● At the inspection in July 2019 we found people were not always involved in their care and support in a meaningful way. At this inspection we found this was still the case, although there had been some improvement.

● One 21 January 2020 we saw a member of staff follow a person as they moved around their home and asked the person to come back to the lounge, or to leave the kitchen area, or to sit back down. They did not ask the person what they may have wanted or suggest things until another member of staff later intervened and helped the person to get a drink.

● The provider had started to hold resident meetings again since our last visit. Records showed these were had been used to discuss issues such as the redecorating the home, personalising people's bedrooms, activities some people had been supported to try, and menu planning.

● People's support plans described how people made some choices about their care. For example, how they chose clothes to wear or food to eat if staff presented them with options. Relatives said they were involved in people's support planning so they could advocate for their family members. One relative said in the past opportunities for their involvement had been "Hit and miss" and this had improved recently.

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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 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. At this inspection we found some improvements had been made but the provider was still in breach of Regulation 9.

● At the inspection in July 2019 we found the provider did not ensure people regularly participated in meaningful activities which offered stimulation or met their individual interests while they were at home. At this inspection we found this to still be the case, although there had been some improvements. This meant the service did not consistently support people to experience a good, meaningful everyday life as people were not receiving care always personalised for them to meet their needs and preferences.
● On the days we visited before and after lunch we observed staff support people to sit for periods of time in the lounge with either music or the television playing. Staff spoke with people in a kindly way but this interaction was intermittent and often only for short periods of time. On 20 January 2020 we observed staff suggest a painting or colouring activity to some individuals but when people declined this staff did not offer any alternatives.
● During our visit we observed staff support some individuals to sit in their wheelchair in the sensory room with music playing, but with little or no staff interaction to help make this an engaging experience.
● Daily records of care from the months prior to our visit indicated the significant majority of people's time when at home was spent sitting in the lounge or sensory room with the television or some music on.
● We received mixed feedback from others about the activities support provided to people. Some adult social care professionals told us this had improved as staff engaged more with people during the day and commented, for example, they had supported some people to create art work. Some professionals had noted people still did not benefit from regular meaningful stimulation during the day. Similarly, some relatives told us they were concerned about the lack meaningful activities for people. One relative said, "I hope there would be more effort around activities inside and outside."
● We saw the provider had devised weekly activity timetables for each person. However, people's support plans did not set out guidance or planned approaches on how to support people to engage in activities. This meant people did not always receive planned and co-ordinated support that was appropriate to meet all their needs.

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 continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did see some improvement in the engagement opportunities provided to people at home. Staff had recently arranged for yoga sessions to be held with people. Records of daily care indicated people had been supported to access the kitchen more regularly during meal preparations and some staff had held music and dance sessions with people. On 20 January 2020 we observed staff initiate a fun game with balloons with some people for a short time. On 21 January 2020 we saw staff practice sign language with people for a short time when this was being demonstrated on a television programme.
● At the inspection on July 2019 we found people were not supported to regularly access their local community. At this inspection we found this had improved for some people. Staff had supported people periodically to go out shopping, for meals, to parks, the hairdressers, and out for walks. People had started to access weekly one hour sessions at day centres. Staff had supported one person to go to the cinema.
● At the last inspection staff told us the service's wheelchair-accessible vehicle could not be used due to a fault. At this inspection we found this had been repaired which meant some people had more opportunities to access their community, such as going shopping or for a drive, and we saw this take place. However, only the deputy manager was able to drive the vehicle. They told us the provider planned to recruit more staff who could drive.
● People's support plans also described how to meet their personal care needs, such as washing and dressing support. This included whether people preferred to be supported by male or female staff. Plans provided some information on people's other preferences, likes and dislikes. For example, one person's plan set out how they liked their plates and bowls to be a particular colour.

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 in July 2019 we found the provider had not fully implemented the AIS to meet people's communication needs. At this inspection we found this was still the case, although there had been some improvements.
● Staff did not always meet people's communication needs in a coordinated and consistent manner. There were now planned approaches for staff to support people whose behaviours may sometimes challenge others with screaming. These required staff to promote positive communication and interactions, for example by using picture cards to help a person choose which room they wanted to be in. However, we observed staff provide this support and use these cards inconsistently.
● On a number of occasions we observed staff start to speak with a person or ask if they were ok, but when they received no response the interaction stopped. While staff we spoke with demonstrated a good understanding of people's care needs, some also described people's screaming behaviour as sometimes being only "Attention-seeking". This indicated people did not always experience support that recognised and met their communication needs. We discussed this with an adult social care professional involved with the service so they could continue to work with the service to improve people's communication support.
● We also observed staff at times being responsive to and interacting meaningfully with people. For example, we saw staff being attentive and taking time to help a person choose where they wanted to eat their lunch. A relative told us the staff's approach to people had improved. They commented, "The way staff communicate, they seem to have a better approach - more animated, rather than a monotone approach."

● The provider had reviewed people's support plans since our last inspection. Plans now recorded more personalised information about how people communicated.
● We saw the provider had held 'active support' training since our last inspection to encourage staff to involve people in more aspects of their daily living. Not all the staff we spoke with could explain what this meant in practice, although staff gave us examples of how they supported people in this way. For example, in setting and clearing the dining table and other tasks around the home.

Improving care quality in response to complaints or concerns
At the last inspection we found the provider had not updated their complaints policy in line with published guidance on raising complaints about adult social care services. At this inspection we found the provider had updated their policy appropriately.
● The provider had appropriate arrangements in place for handling complaints. These included advising complaints they could refer their issue to the local commissioning authority and the Local Government Ombudsman. There was easy read information about giving feedback to the provider and making complaints, although it was not clear people using the service could understand this.
● Relative told us they now felt they would be listened to if they raised an issue and this had not always been the case in the past.
● The provider had received one expression of dissatisfaction since our last inspection which staff responded to appropriately.

End of life care and support
● No one was receiving end of life care and no one had been diagnosed with any life-limiting conditions at the time of our inspection.
● People's support plans showed potential end of life care needs and arrangements had been considered based on people's known likes and preferences.

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. 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
At our last inspection we found the provider's audit systems for monitoring the quality and safety of the service were not operated effectively as the systems had not successfully assessed and made improvements to the quality of care, activities and staff interactions that people were experiencing at home. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made but the provider was still in breach of Regulation 17.

● At this inspection we identified there were still ongoing breaches of Regulations. The provider had not ensured support arrangements set out how to avoid people experiencing the risk of skin damage and discomfort. The provider had not made sure people were treated with dignity and respect at all times and consistently experienced good and meaningful everyday lives.
● We have identified breaches at this and the two previous inspections. We have taken enforcement action at the previous two inspections. However, the provider has failed to comply fully with this action, despite providing assurances they would. The systems to improve the quality of the service have not been operated effectively enough to ensure that people always received good quality care and support.

Failure to operate governance systems effectively was an ongoing breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found the provider had not informed the CQC of an allegation of abuse, as required by the regulations. At this inspection we found the provider was aware of their responsibility to notify us of important events and did so.
● Despite the concerns we found, we also recognised the provider had made some improvements at the service. The provider had implemented additional quality monitoring processes since our last inspection. These included a regular, recorded 'walkarounds' where the managers assessed aspects of the home environment and how people were being supported. We saw managers took action to address issues these checks identified. Other periodic quality audits included reviews of the medicines administration records and infection control processes, health and safety monitoring and checking of the money held on behalf of people.
● There had been leadership changes at the service since our last inspection and people spoke positively about the new managers. Staff said of the managers, "[They] have good experience, it is what this house

needs" and they felt supported by them. Another said they appreciated a manager coming to the service on a Sunday to help celebrate a person's birthday

● There was still no registered manager in post when we inspected. The new deputy manager told us they would be applying to register with the CQC.

● Adult social care professionals told us they thought the management team had improved. Relatives also said this and one commented, "It is a different way of management, [the manager] likes things really in place." However, relatives also expressed concern that if there were more changes to the management team this would undo any improvements made. Their comments included, "A good home needs good consistent manager."

● We saw staff kept up to date records of people's care and support, although daily records of care only contained basic information about what people had been supported with each day. Other records included plans for each staff shift and information about any appointments people attended.

● At the last inspection we found the provider had not conspicuously displayed the last CQC inspection rating on their website, as required by law. At this inspection we found the rating displayed at the service and on the provider's website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

● Professionals and relatives told us people needed to experience sustained improvements and that it was too early to be confident this would happen. A relative said, "There's worry that things could slip again." Managers and staff we spoke with demonstrated a commitment to improving the service and felt some things were better than when we last inspected. For example, staff said the re-decorations, new training and some activities for people were improvements. Some adult social care professionals said they felt the service had made some improvements and was, "Moving in the right direction."

● The culture of the service had improved to better promote the delivery of high-quality care. We observed staff interact with people and each other in friendly and supportive ways. Staff said morale had improved compared to when we last inspected. Some professionals told us they felt the atmosphere in the home had improved. One relative said they had observed, "[A person] seems to be a different person, [the person] seems happier, more animated."

● The managers recorded incidents and the actions taken in responses to these, such as errors with people's medicines.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives had had some opportunities to be involved in the service. The managers had recently arranged family meetings with relatives to discuss and involve them in the service developments. One relative said this was the first time this had happened and they felt managers had listened to them.

● Staff team meetings had started to be held regularly since our last inspection. Records showed these were used to discuss issues such as people's health and well-being, medicines support, menu planning, health and safety, training and adult safeguarding. Staff said the managers were approachable and felt they listened to staff. We saw managers had invited feedback from staff about the running of the service during one to one meetings.

● The provider had not conducted any more stakeholder or feedback surveys since our last inspection.

Working in partnership with others

● Professionals from health and adult social care agencies told us the service had improved in how it

worked with others to staff provide joined-up care to people. Professionals said staff were more prepared for their visits and were more able to share important information about people's needs than they had been in the past. Professionals' comments included, "[Staff were] more on the ball, more client-focused." For example, staff were able to provide appropriate information about people's epilepsy support when required, when healthcare professionals said this had not always been the case in the past.

● The provider continued to work with healthcare and adult social care professionals to address improvement issues at the service, such as the local commissioning authority and behavioural support team.