RRC (GB) Ltd

Restoration Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Restoration Residential Care Home provides care and accommodation to people with mental health needs. The service accommodates up to four people in one building. At the time of our inspection, three people were living there.

People's experience of using this service and what we found
The provider had failed to ensure that people were supported in a safe way. Risk assessments did not identify and mitigate individual risk; medicines were not being managed safely; recruitment practices did not ensure staff were suitable to support vulnerable people and there was no recording or analysis of accidents and incidents. We also found that the systems in place to protect people from infection were not adequate. This placed people at risk of harm or unsafe care.

People's needs were not adequately assessed. There were shortfalls regarding staff training and support through supervisions. The service did not support people to have a healthy, balanced diet and to stay well through engaging with other health and social care professionals. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems did not support this practice. The service was not always designed and adapted with people's needs in mind.

People were not always treated in a kind manner. The service lacked a consistent approach to people and their relatives being involved in the care and support they received. The service was failing to ensure it promoted a culture of equality and diversity. People's privacy and dignity was not promoted.

Care plans remained inconsistent and did not always guide staff to provide person-centred care. People were at risk of social isolation and did not engage in community activities. We found that the systems in place to manage complaints and end of life care were insufficient.

The quality assurance systems were inadequate as they had not identified the shortfalls we found during our inspection and did not ensure people were always kept safe. We found the service failed to demonstrate they were providing care and support that was safe, caring, effective or responsive. This put people at continued risk of harm.

However, staff were up to date with safeguarding training and told us they felt supported. There were enough staff to meet people's needs. Relatives told us they felt their loved ones were safe.

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

Rating at last inspection
The last rating for this service was good (published 1 June 2017).

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement
We have identified breaches in relation to person-centred care, consent, safe care and treatment, receiving and acting on complaints and good governance at this inspection. Please see the action we have told the provider to take at the end of this report. 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Restoration Residential Care Home

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
The inspection was carried out by one inspector.

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

Notice of inspection:
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with 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. We used all this information to plan our inspection.

What we did during the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. We spoke with two members of staff including the registered manager.

We reviewed a range of records. This included two people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service, including policies and procedures were reviewed.

What we did after the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at risk assessments and photographs of the garden.

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People's risk assessments did not identify specific risks, and these were not reviewed on a regular basis to ensure they reflected people's up to date needs, which placed people at risk of harm.

● For example, under one person's pre-admission assessment it indicated they had been diagnosed with six different medical conditions related to both their mental and physical health. However, there was only one risk assessment in place, for one of the six medical conditions. Furthermore, following the inspection the registered manager emailed us a risk assessment for a medical condition that was not listed throughout their care plan. We found this specific risk assessment was not tailored for this person as the potential complications were not possible. This placed this person at potential risk of harm, as staff were not provided with accurate information regarding their health conditions and associated risks.

● Another person had lost a lot of weight and was at risk of choking, but no action had been taken to support the person with the risks associated with this and there was no risk assessment in place regarding this. The service had failed to assess individual risks to people to ensure they received care and support that kept them safe

● For one person, prior to moving in, the home had advised they needed support from both male and female staff to support them with an associated risk. However, we were advised by the registered manager, and records confirmed that the service only recruited female staff. This means that this person, other people within the home and staff were not protected from potential risk of harm.

● Staff told us if there were any risks, they would read the risk assessments for guidance on how to support people. However, they felt there weren't any risks to be mindful of. One staff member said, "People here are so good, there aren't really any [risks]." This demonstrated that staff were not provided with enough instructions to guide them on how to keep people safe.

Risk assessments were inadequate and did not guide staff to know how to provide safe care and treatment. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not being managed safely; the systems in place to ensure the service understood people's support needs in relation to their medicines was inadequate.

● There were no specific risk assessments in place for people's medicines. Although there was a record of the names of the medicines people received, it was not clear why they were prescribed these medicines, how they supported people to keep well, how they were affected by their medicines or how staff should support them with their medicines. This means staff could miss an important indicator in relation to people's medicines and associated risks and would not know how to respond to keep them safe and well.

● For one person, there was no evidence they had ever had a medicines review. For another person, we found their medicines had been reviewed in April 2019 and their prescribed dose for a specific medicine had increased. This person's care file was not updated to reflect this change. This meant there was a risk that staff may not provide this person with the correct dosage of this medicine, as prescribed by a health care professional. Furthermore, if staff needed to share this information with other health and social care professionals there is a risk that the wrong information would be given. This could put the person at risk of harm.

Medicines were not being managed in a safe way and people were not protected from potential harm. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we received an audit sheet to show people's medicines were reviewed. However, this was incomplete as one date was in the future and the other two reviews had no comments. It was therefore not possible to know what a review involved or what the outcome of the review was. As a result, staff might not know how to manage medicines in a safe way for people.
● In addition, we received updated medicines profiles for two people. This also appeared incomplete, as for some medicines it said, "GP to advise" when asked why they were prescribed this medicine. We also found medicines were prescribed for medical conditions that were not listed on this person's care plan or risk assessment."
● Records confirmed that the provider did carry out audits of Medicine Administration Records (MAR). Furthermore, staff were up to date with their medicine training and were assessed for their competency to ensure they were able to manage and administer medicines in a safe way.

Learning lessons when things go wrong
● Accidents and incidents were not being reviewed and action was not being taken to minimise reoccurrence and to keep people safe.
● Records to document when accidents and incidents had occurred were not readily available and the registered manager advised us there had been none. However, we found them in an audit folder kept by the registered manager. These showed that accidents and incidents had occurred but were not investigated further or analysed for trends. For example, we found that in 2019 (no specific date was listed) one person collapsed while eating. Records show that a GP was called and advised staff to monitor the person but there were no records to show what actions were taken to keep this person safe. There was no investigation to look at lessons learnt and to prevent reoccurrence. This was of concern as this person had medical conditions associated with collapsing that were not taken into consideration. We found other records to show people had fallen and there was no further analysis or investigation. These people were not referred to or reviewed by any other relevant health and social care professional to ensure they were safe and well.
● This demonstrated that the service did not effectively monitor the care and support provided to people ensuring lessons could be learnt to minimise risks and ensure people were always safe.

Accidents and incidents were not recorded and analysed to identify patterns and reduce the risk of harm to people. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we received an 'accident and incident' audit and analysis. However, we found this was not complete for all accidents or incidents and it remained unclear what had been done to keep the person safe from harm."

Staffing and recruitment

● There were enough staff to meet people's needs. One staff member told us, "Staffing is fine. It balances out."

● Records confirmed most staff were permanent and had worked at the service for a long time. This had provided people with continuity of care from a team of staff who they were familiar with.

● Safer recruitment practices were mostly followed. Pre-employment checks such as Disclosure and Barring Service (DBS) checks, references and proof of identity had been carried out as part of the recruitment process. However, in one person's recruitment file their employment history was not completed and there were differences between documents provided by this member of staff to evidence their employment history. This meant the systems in place could not guarantee people were protected from the risk of unsuitable staff being employed by the service.

We recommend the service follows best practice guidelines to ensure they were managing recruitment of staff in a safe way.

Preventing and controlling infection

● The service had an infection control policy in place and observations confirmed staff were mostly taking appropriate measures to protect people from cross infection. We observed one staff member speaking to a person and advising them on the importance of washing their laundry regularly. There was hand gel available throughout the home. The home appeared clean, and well maintained.

● Relatives we spoke to confirmed they had no concerns around the cleanliness of the home.

● However, there was no clear system in place for staff to manage soiled laundry and it was not clear how this was being separated from other laundry loads.

● We found that not all food had been labelled with its opening date. Therefore, people may be at risk of consuming food that is out of date or no longer safe to eat.

We recommend the service follows best practice guidelines to ensure they were managing the risk of infection.

Systems and processes to safeguard people from the risk of abuse

● There were processes in place to ensure people were protected from the risk of abuse. One relative told us, "I am not worried about [person's] safety."

● Staff were aware of safeguarding procedures, knew how to identify abuse and how to report any concerns to protect people from harm. One staff member told us, "I would speak to my manager."

● The registered manager told us, and records confirmed that all staff were up to date with their safeguarding training and knew when to report incidents of abuse to relevant organisations.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● We looked at two people's care plans and saw that MCA assessments or best interest assessments had not been completed and there were no completed consent forms in place. There were no other signatures throughout this person's care plan to indicate this person had the capacity to consent to receiving care and support.
● Where people had a DoLS in place, they contained specific conditions to help keep people safe. We found the service had, in some circumstances, introduced additional restrictions which were not mentioned in their DoLS authorisation. For example, one person's DoLS said they were, "Independent with personal care and toileting but requires occasional prompting." However, the registered manager advised us that this person could not manage toileting independently and at certain times they locked this person's bathroom to prevent them accessing the toilet. There was no MCA assessment for this specific support need, no best interest meeting had been held and a relative confirmed they were not aware of or involved in the decision-making process.
● One person was restricted within the home; when they were not with staff, certain rooms of the home were locked, and they could not access them independently. However, there was no DoLS in place. Furthermore, there was no MCA assessment for this specific support need and no best interest meeting had been held.

The service was not providing care and support in line with the MCA. As a result, people were at risk of having decisions made without their consent and not in line with their best interests. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we received one person's MCA assessment relating to the decision to live at the service. There was no evidence of other areas of this person's life having been assessed.
● However, staff told us consent was obtained before providing care and support. One staff member said, "This is like the authorisation from an individual. A legal way of saying 'yes I do' or 'no I do not.'" Records confirmed staff were up to date with MCA training.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There was limited evidence of engagement with other services to offer holistic care and support in line with people's needs. One staff member confirmed, "No, there is not much involvement."
● We reviewed individual care plans and found that contact details of other health and social care professionals were not always completed. We could not see many records to evidence people were receiving reviews from other health and social care professionals. One relative confirmed, "Not as far as I know" when asked about multi-agency involvement.
● We found records to confirm that one person had collapsed, and another person had fallen two times. The service had not contacted other health and social care professionals to review their health conditions and ensure this person received support to keep them safe and well.
● The registered manager had created a bag for one person who often went into hospital. The registered manager told us this bag was to be ready for an emergency admission and should contain relevant details about this person to ensure other relevant health and social care professionals would know about their support needs. However, we found the details within the bag were mostly blank as it contained no next of kin details, no guidance on communication and other support needs and the person's medicine profile was out of date. In the event of an emergency admission, staff may not have had time to complete this. As a result, this person's experience between services may not meet their needs.
● This meant the service had inadequate systems in place to ensure people had access to healthcare services and received appropriate care and support in a timely manner which may have put them at risk of harm.

The provider had failed to actively work with other relevant professionals to make sure that care and treatment was safe for people using the service. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service received referrals from the local authority that contained information about people's care and support needs. People's needs were then assessed by the service before they began using the service.
● Assessments covered different areas of people's lives where they may need support. They included information about their health and welfare, their personal safety and risks, their social networks and a variety of other topics that provided insight into their needs and preferences. However, these needs and preferences were not then reflected throughout people's care plans and could not be evidenced through daily records.
● For example, one person's assessment said their favourite sport was badminton and their favourite colour was blue. But their care plan said they would be encouraged to access activities including yoga and swimming, and their bedroom was decorated in yellow. Two people listed their favourite instruments as

piano and the flute but there was no evidence of people being supported to play instruments in the home or listen to music. It was not clear, therefore, if people's needs had been accurately assessed or were being met.

This showed that the provider had failed to carry out an appropriate assessment of needs and preferences of the person to provide effective care and support. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● During the inspection the registered manager told us people were supported to choose what they would like to eat each day, using pictures. There were no records to indicate people could not verbalise what they would like to eat, and no use of pictures in other areas of their support. The registered manager advised no previous examples of menus were available and suggested it had only been implemented on the day of the inspection. When we spoke with people about what they had eaten for breakfast and lunch, it did not match what their menu said. This showed that the service did not ensure people were effectively communicated with about their meals.

● We also found that people were eating processed food and did not have a choice of, or access to any fruit or vegetables. We also saw there was a bottle of wine on the table, despite one person having an associated risk related to alcohol. The registered manager told us this was going to be used in cooking and staff should not have left it out. It was not put away during the inspection.

● Two people living at the service had diabetes, and one person was at risk of choking. There were no assessments in place, or other records to guide staff to manage people's diet and food intake in line with these specific risks. This demonstrates people were not supported to maintain a balanced diet and stay well and people were at risk of harm through their nutrition.

The provider had failed to ensure people received care and treatment that met their support needs and supported them to stay healthy. This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● We found that the garden was not well maintained or inviting for people to access. There was no garden furniture available. One relative told us they would like to see some, as their loved one did not go outside of the service. People told us they rarely went outside. There was a small patch for plants, but this had not been used and it was covered with weeds. Behind one garden shed and across the garden there were disused items including an exercise bike, a fridge and other items including broken fencing, panels and paint. A second garden shed was not locked and had items in it including people's used laundry and old equipment. We discussed the maintenance of the garden with the registered manager and they told us, "Our maintenance doesn't work in the winter."

● In one of the living rooms we saw a board game was available for people to play, and a computer for people to access. However, the board game had been chosen by the registered manager and the computer did not work.

● Throughout the home we saw some evidence of it being decorated and designed with people's preferences in mind. For example, in the living room a tree had been painted with a portrait of each of the people living there attached to a branch. People's bedrooms had photographs of loved ones in them and other items of their choice. However, there was no evidence people had been consulted about the decorating.

We recommend the service ensures people's preferences and needs are considered when designing the

home.

● Following the inspection, the registered manager sent us some photographs to show some areas s of the garden had been cleared, but not all areas.

Staff support: induction, training, skills and experience
● We reviewed staff training records and found that not all staff had completed relevant training. For example, none had completed training on how to support people living with diabetes, or specific mental health conditions. As staff were providing support to people affected by these conditions, people were at risk of receiving inadequate care and support from staff who were not suitably trained.
● Mostly, staff received regular supervisions and an annual appraisal. One staff member told us, "Most of my supervisions go well. Whatever difficulties I come across [registered manager] does assist me." However, the registered manager told us these were completed every two months, but records confirmed one staff member had not received supervision for five months. This meant they were not always supported to be up to date with best practice guidance and felt able to provide effective care and support to people.

We recommend the provider ensures their policies and procedures supported staff to provide effective care and support.

● New staff received an induction, which included shadowing a more experienced member of staff and learning about the policies and procedures of the service.
● Staff told us, and records confirmed all staff had completed or were in the process of completing the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. One staff member said, "I find the training very informative. The Care Certificate standards allow you to reflect."

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Supporting people to express their views and be involved in making decisions about their care
- People or their relatives had not been involved in planning their own care and support and it was not clear whether or not their preferences had been taken into account. One relative confirmed they had not been invited to any reviews and had not seen a copy of their loved one's care plan.
- People's care plans lacked records or signatures to confirm people and their relatives were involved in making decisions and reviewing their care.
- It was not clear whether or not people had been involved in making choices or supported to understand their care and support arrangements, or what steps the provider had taken to ensure they could make choices for themselves.
- This meant that people's care may not be delivered in a person-centred way, in accordance with their own wishes, as they had not been involved in the planning of their care.

The provider had failed to support people to participate in making decisions relating to their care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
- We found the service did not work in a manner that respected people's privacy and dignity. We observed staff had conversations about people in front of others; these conversations were related to support needs. We also observed the registered manager speaking to people in an abrupt and disrespectful manner. They regularly bought attention to one person's personal care needs in a mocking tone and in an open environment. We also found that the registered manager responded to people in a dismissive way and did not respond to their queries in a timely manner.
- Within one person's care plan we did see some evidence of their protected characteristics being discussed in relation to sexuality and relationships. However, this was not a consistent approach for others, and there were no records of people's cultural and religious needs.

This showed that the service did not always treat people well, respect privacy and the systems in place to ensure staff were working to protect people from potential discrimination were inadequate. This was a breach of Regulation 10 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed one staff member treating people with kindness and compassion and promoting independence. For example, when helping people put up the Christmas Tree they ensured each person had an opportunity to be involved and gave them roles that suited their abilities. This staff member said, "I love my job. I love caring for people." One relative confirmed, "[Person] is happy there and the [staff] are nice."
● The service had an equality and diversity policy in place and staff had completed training in equality and diversity.

Inadequate

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 good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People's care was not always provided in a person-centred way. There was a lack of clear information and some inconsistencies in people's care plans, which made it difficult to know how people wanted to spend their time and how best to support them to maximise their health and wellbeing.
- For example, one person's care plan said, "Unable or reluctant to communicate both verbally and non-verbally," but another part of this person's care plan said, "[Person] is able to say how [person] feels." This person's care plan also said staff were to provide them with information and assist them in participating in activities. However, none of the activities listed matched with what this person had expressed an interest in throughout other areas of their care file.
- When we spoke to people during the inspection, their examples of how they spend their time was limited; they could not tell us about many things they did. One relative confirmed, "I wish [person] would go out more. I think [person] needs more stimulation. [Person] doesn't sort of seem to do anything." One staff member told us, "I try to encourage them not to sit in their room. After dessert we can have movie nights." But they were unable to tell us about community outings.
- A second person's care file said they previously had a job and volunteered in the local community; when moving into the service they were to continue to receive support to live independently. However, there was no evidence this had been achieved. This person told us they only met people when they went out for their medication. The registered manager told us this person, "Went out every day." We found that this person went to the local shops regularly but were not supported to go anywhere else.
- This showed that people's care plans did not fully reflect their preferences and guide staff on how to provide care that is person-centred. People did not have an opportunity to build relationships with other people in the local community or access community events.

This placed people at risk of social isolation and of not receiving the care that they required. This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, we received photographs to show people were supported to go shopping, eat out and decorate communal areas.
- However, we also received evidence to show one person wanted to do gardening and grow vegetables as well as other outdoor activities, but this had been achieved. This further evidenced that activities were not always delivered in a person-centred way.

Meeting people's communication needs; Improving care quality in response to complaints or concerns
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.

● The registered manager had not heard of the AIS. It was not clear within people's care records about their communication needs and whether they had capacity to understand specific information or if they could read, write or verbalise their thoughts and feelings. As the provider had failed to assess people's communication support needs in detail it was difficult to know what examples of AIS might be necessary throughout the home to enable people to understand and provide feedback about their care.
● In the reception area of the service, we found an empty box that was labelled as 'Complaints and Concerns'. The registered manger told us, "The forms had been removed because of [person] stealing them." There was no reassurance that this person's behaviour had been explored or alternative methods of allowing people to raise complaints or concerns had been considered. The registered manager later showed us some 'Complaints and Concerns' that were hidden behind other documents; however, they were not readily available.
● In the registered manager's audit, we found that on the 25 June 2019 questions about whether 'complaints forms were available for people' and if 'complaints records were up to date' were both blank. The registered manager told us there was no complaints folder, as there had never been any complaints. However, within the registered manager's audit we found one complaint had been raised by a person regarding the quality of care they had received. Records show this had been discussed with the team, but there appeared to be no clear evidence of an investigation or response to the person who had raised the complaint. Furthermore, in 'minutes of a 'resident meeting' from the 3 June 2019, one person had raised a complaint about a potential breach of their privacy. The minutes then said, "Identity is [staff initials]." Similarly, there appeared to be no clear evidence of an investigation or response to the person who had raised the complaint.

The provider had failed to establish and effectively operate an accessible system for identifying, receiving, recording, handling and respond to complaints. This demonstrated a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager emailed us to evidence 'Complaints and Concerns' forms were now visible in the reception area."
● One relative told us, "Never had to make a complaint. If I have any concerns I will raise it and it is usually fixed quite quickly. For example, [person] wanted a [item for their bedroom] and they got us the money to get one."

End of life care and support
● We checked whether the service had explored people's preferences and choices in relation to end of life care and if systems were in place to enable staff to provide adequate end of life care.
● We found that people had 'end of life' care plans in place. However, they were not fully completed and there was no evidence they had been completed in a person-centred way. For example, one person's end of life care plan said they were of a specific religious denomination despite their pre-admission assessment and care plan advising they had no religious beliefs. A second person's 'end of life' care plan had sections for their religion, further information, photograph, hobbies, interests and wishes about who could be told about their death. However, these were all blank and incomplete. This suggested people were not spoken to in detail about their wishes.

● We spoke to the registered manager about this who told us it was difficult to speak to people about end of life. There was no evidence any family members or other relevant people including health and social care professionals had been consulted.

The provider had failed to assess and respond appropriately to people's changing needs to ensure they received end of life care that met their needs and preferences. This demonstrated a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, records confirmed staff had received end of life training as part of the Care Certificate.

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 good. At this inspection this key question has deteriorated to 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; Continuous learning and improving care, engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- We found the quality assurance systems to monitor the service were inadequate. The registered manager's audits had failed to identify the concerns we found in relation to risk assessments; medicines; safe recruitment practices; infection control and the analysis of accidents and incidents.
- There were ongoing shortfalls identified with staff training; assessing people's needs; people's nutrition and working with other health and social care professionals and the design and adaptation of the home. The service was not working in line with the Mental Capacity Act 2005. We did not find a consistent approach to people and their relatives being involved in their care or being given an opportunity to give feedback. Furthermore, when people did give feedback about their care it was not always listened to or responded to appropriately.
- One relative confirmed they had never been asked to provide any formal feedback. The service was failing to ensure it respected people's dignity and protected people from discrimination. Care plans were inconsistent and did not always guide staff to provide person-centred care in line with their communication needs. We also found that the systems in place to manage complaints and end of life care were insufficient.
- Not all audits to oversee the running of the service were complete. Specifically, the audit for staff supervisions had not been updated since September 2019. We also found that the 'Care Plan 6 monthly review'; 'Key working audit''; 'Resident review audit'; 'Maintenance' and 'COSHH products' audits were blank.
- The registered manager did not complete any form of checks on the running of the service either through observed practice, competency assessments or unannounced visits. These can be used as a quality assurance measure.
- The registered manager was mostly aware of their legal responsibilities and of their duty to notify the Care Quality Commission (CQC) of significant events. However, we found they were not aware of their duty to notify us of an outcome of an application to deprive a person of their liberty (DoLS). This means that the CQC cannot maintain oversight and monitor the care and support provided to people and check the provider was following health and social care regulations.
- The registered manager and staff told us they did not work in partnership with other health and social care professionals to ensure a culture of continuous learning and development.

The above evidence shows that the service has failed to establish effective governance systems or processes to oversee the running of the service and monitor, assess and improve the quality and safety of the services

provided to service users. This demonstrated a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we received surveys from people, relatives and other relevant people that had been completed in April 2019. However, the service guidance says these are to be completed every two months but there was no evidence this had been done. Furthermore, where people and neighbours had identified concerns we could not see any actions taken to rectify this. For example, one person rated the service "Requires Improvement" for being supported to keep up their hobbies, get involved in the community and be supported to explore their hopes, likes and needs.
● However, staff told us, and records confirmed that staff attended regular team meetings to discuss the running of the service. One staff member said, "We all work well together. Never had a problem." Staff spoke positively about the registered manager. One member of staff said, "She listens, she is good."

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.
● Due to the concerns we identified with the processes for receiving and acting on complaints, we could not be assured that the provider fully understood their responsibility with regard to their duty of candour.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people working in partnership with others;
● There was not always a positive and person-centred culture at the service.
● People did not always speak positively about the registered manager. One person told us they found the registered manager was, "Rude" and, "Does things her own way." A second person did not comment when we asked for their feedback about the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out appropriate assessments of the needs and preferences of people to provide effective person-centred care and support. The provider had failed to support people to participate in making decisions relating to their care. The provider did not always treat people well, respect privacy and the systems in place to ensure staff were working to protect people from potential discrimination were inadequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not providing care and support in line with the Mental Capacity Act (2005). As a result, people were at risk of having decisions made without their consent and not in line with their best interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care

Receiving and acting on complaints

The provider had failed to establish and effectively operate an accessible system for identifying, receiving, recording, handling and responding to complaints.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were inadequate and did not guide staff to know how to provide safe care and treatment. Medicines were not being managed in a safe way and people were not protected from potential harm. Accidents and incidents were not recorded and analysed to identify patterns and reduce the risk of harm to people. The provider had failed to actively work with other relevant professionals to make sure that care and treatment was safe for people using the service and that people were healthy and well.

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish effective governance systems or processes to oversee the running of the service and monitor, assess and improve the quality and safety of the services provided to people.

The enforcement action we took:

Warning Notice.