Diamond Care (2000) Limited

New Redvers

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

New Redvers is a residential care home that provides personal care and support for up to 19 people with a learning disability, autism or who have complex needs associated with their mental health. At the time of the inspection there were 11 people living at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people

People's experience of using this service and what we found.
The provider could not show how they met some of the principles of Right support, right care, right culture. This meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

People told us they were happy, and they liked living at New Redvers. One person said, "I like living here." Another said, "We have had a lot of staff changes here, I miss some of the old staff, but I like the new staff too. They are very nice." Another person said "Since (name of CEO) and (name of consultant) have been here it become 1000% better. They have been spending money decorating. We have some chickens; food is much better and hopefully we are getting some pigmy goats."

Although people told us they felt safe and were happy living at New Redvers, the service did not focus on people's quality of life, and care delivery was not person centred. Staff knew people well, but they did not recognise how to promote people's rights, choice or independence.

The culture of the service did not reflect best practice guidance for supporting people with a learning disability or autistic people. Senior managers and staff did not understand the underpinning principles of Right support, right care, right culture guidance, or how these could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhanced their expectations, increased their opportunities and valued their contributions.

People's human rights were not upheld, staff used punitive practices as a way of controlling people's behaviour and language used by staff was disrespectful and demeaning. People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs. All of which created a closed culture, which increased people's dependence on staff who had limited understanding of how to support people in a way which upheld their human rights.

People's basic right to privacy and dignity and to be free from all forms of discrimination under the Equality Act 2010, was not always understood by staff or respected. This meant that people experienced a poor

quality of life which was not person centred as staff did not put the needs of people first.

People were not always protected from the risk of abuse or avoidable harm. We found where some risks had been identified, sufficient action had not always been taken to mitigate those risks and keep people safe. Key pieces of information relating to people's care and support needs were not always being recorded or followed up. Other risks were well managed.

People were not supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests.

People who had behaviours that could challenge themselves or others, had proactive plans in place to reduce the need for restrictive practices, however, these were not always followed. Support did not always focus on people's quality of life and staff did not regularly evaluate the quality of support given, involving the person, their families and other professionals as appropriate.

People were not always protected from the risk and spread of infection.

People were not supported by staff who understood best practice in relation to learning disability and/or autism. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

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 12 February 2021). Following that inspection, the provider was asked to complete an action plan to show what they would do and by when the improvements would be made. This was not received by the Commission.

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

Why we inspected
This was a planned inspection based on the previous rating and to provide assurance that the service is applying the principles of Right support, right care, right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make significant improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for New Redvers on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in regulation in relation to safe care and treatment, safeguarding people from abuse, the need for consent, staffing, recruitment, notifications, duty of candour and governance. 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
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 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, 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.

We will meet with the provider following this report being published and 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not 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.

New Redvers

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 team consisted of three adult social care (ASC) inspectors, a medicines inspector and an Expert by Experience who had consent to phone and gain feedback on the care provided by the service from people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
New Redvers is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. At the time of the inspection the service was being managed by the providers Chief Executive Officer (CEO) and a consultant who had been engaged by the provider to make improvements.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection. 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-
We spent time with and spoke with 10 people living at the service, six relatives, four members of staff, a consultant who had been engaged to support the service, the CEO, the Nominated individual and a director of Diamond Care (2000) Limited. The nominated individual is responsible for supervising the management of the service on behalf of the provider. To help us assess and understand how people's care needs were being met we reviewed six people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

We used the Quality of Life Tool and 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with six health care professionals, and representative from Torbay Council's quality assurance and improvement team (QAIT) and one relative. We made five safeguarding referrals and advised a health care professional to raise another.

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 previous inspection October 2020, we found the provider had failed to effectively establish systems to investigate and report allegations of abuse. This placed people at an increased risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 13.

• People were not protected from the risk of abuse or exploitation. For example, records for one person indicated they may have been placing themselves at the risk of abuse and/or exploitation by their actions. Action had not been taken by the CEO, staff or the consultant to keep this person safe.
• Although people told us they felt safe, they were not protected from the risk of avoidable harm and some staff used punitive practices as a way of controlling people's behaviour. The CEO and consultant did not recognise some staff actions as safeguarding concerns and failed to take action to keep people safe; uphold their human rights or address the poor culture within the service, that saw the person as being at fault or blamed when they were experiencing periods of emotional distress. For example, one person was told they would not be able to go for a meal or purchase items due to their 'behaviour'. And that their, "Constant behaviour will have consequences on activities planned". Another person was told they could not go out in their wheelchair as they had put on too much weight.
• Staff had recorded 11 safeguarding incidents between February 2021 and June 2021. All these incidents had been reviewed by either the CEO or the consultant, however, they had not recognised them as abuse and failed to report them to the local authority for further investigation and follow up. Nor did they see this as an opportunity to understand and support people to manage their emotional distress and reduce the risk of reoccurrence.

The failure to ensure people were safe from abuse and improper treatment was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they liked living at New Redvers and felt safe. One person said, "I like living here the staff are nice". Another said, I do feel safe here, it's much better now." Relatives did not raise any concerns about people's safety. One relative said, "[Person's name] seems happy there…we have never had anything to worry about" Another said, "When they first took over it was not very safe here, it has improved a lot in the last twelve months, they are trying hard."

At the previous inspection we found the provider was failing to ensure they were doing all that was reasonably practicable to manage and mitigate risks. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation.

• People were not always protected from risks associated with their assessed complex care needs. For example, one person who required the use of bedrails to maintain their safety had fallen from bed in November 2020. No action had been taken by staff or the provider to mitigate/reduce or prevent reoccurrence. In May 2021 this person sustained a second fall from bed resulting in a fractured bone.
• One person had been assessed by a Speech and Language Therapist (SALT) and required a texture level 6 "soft bitesize" diet to minimise the risk of choking. There had been four recorded episodes of choking since January 2021 where this person had required intervention from staff to clear their airway. A staff member told us they were concerned this person was not always sitting in a good position when eating and some staff were giving them foods that could place them at risk of choking. Records for April and June show this person was given rice cakes, jelly babies, crackers, coleslaw and an apple. This placed the person at an increased risk of choking.
• One person was experiencing regular seizures. There were no care plan or risk assessments in place regarding this person's seizure activity. Information regarding seizure activity had not been recorded or shared with the person's GP.
• People were not always involved in managing their own risks, whenever possible. The provider had not ensured risks were anticipated and managed in a person-centred way. We did not see a culture of positive risk taking and there were limited opportunities for people to increase or maintain their independence.
• Staff did not maintain high quality care records. Information recorded about people did not reflect people's planned care or assessed needs to show it was fully delivered. Nor did they show that people were always treated in a way which valued and respected them as adults and upheld their basic human rights. Several records noted staff had told people during periods of anxiety or emotional distress, that their behaviour was 'unacceptable'. Following one incident, a staff member had recorded, "Presented behaviour that was challenging he wanted to go to the pub for a drink with his money," "Took [Person's name] to the quiet room and explained it's not nice to speak to people like that and also not to shout at staff". Another recorded, "Presented behaviour that was challenging, moaning about yesterday as staff had told him off." The CEO and/or the consultant signed these forms off without querying the language being used or what had happened.
• The provider did not keep people and staff safe. The provider did not have a good track record on safety and had not demonstrated an ability to manage accidents and incidents well. Managers did not investigate or use the learning from accidents and incidents to maintained people's safety.

The providers failure to ensure they were doing all that was reasonably practicable to manage and mitigate risks placed people at an increased risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At the previous inspection we found the provider failed to ensure that risks relating to infection control were being effectively managed. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvement had not been made and the provider was still in breach of regulation 12.

• People were not protected from the risk and spread of infection. We were not assured that the provider was doing everything possible to prevent people, visitors and staff from catching and spreading infections. Whilst the provider had in place procedures for visitors entering the service, we found these were not always being followed.
• We were not assured that staff were using PPE effectively and safely. For example, on the first day of the inspection we observed a staff member assist a person with a meal. The staff member was not wearing a face mask and the person they were assisting had a known history of chest infections.
• We were not assured that the provider was meeting shielding and social distancing rules. People were not supported or encouraged to socially distance whilst in communal areas of the home. This placed people at

risk from the spread of COVID-19.
• We were not assured that the provider was promoting safety in relation to hygiene practices. The service appeared clean; however, we did not observe staff cleaning high frequency touch points/areas during our site visits nor did the provider have in place an enhanced cleaning schedule.
• We were somewhat assured that the provider was accessing testing for people using the service and staff. The provider did not require staff to formally record LFD (lateral flow device) test through the government portal nor did they keep any records of staff LFD testing / results internally.

The provider failed to ensure that risks relating to infection control and the transmission of Covid 19 were being effectively managed and this placed people at an increased risk of harm. This was continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they understood how to be safe when they were out and about. One person said, "Staff always make sure we have our masks on if we go out." Another said, "I always wear my mask on the bus, when I visit my …"

At the previous inspection we found the provider failed to ensure sufficient numbers of staff were deployed appropriately to meet people's assessed needs. 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 improvement had not been made and the provider was still in breach of regulation 18.

• People were placed at the risk of harm as staffing arrangements at night and during the day were not sufficient to meet people's needs safely. Neither the CEO or consultant who were in day to day control of the service were able to tell us what 1:1 hours had been commissioned for the people living at the service, apart from one person who they confirmed was commissioned for eight hrs of 1:1 support each day. Our observations identified this person did not receive the commissioned eight hours 1:1 support on all three days of the inspection.
• There was no formal assessment in place or dependency tool to identify what staffing was needed to meet people's need safely both during the day and at night. We found one person's care plan identified they needed to be repositioned every two hours to minimise the risk of pressure sores.
• Another person required staff to check on them hourly throughout the night and required the use of emergency medicine for the management of their epilepsy. Another person required the use of oxygen therapy during the night and required staff to check on them hourly. Current night-time staffing cover consisted of one waking and one sleeping staff member who was in a separate flat at the top of the building. This meant that should the staff member need support in an emergency or to provide routine care such as repositioning or personal care they would have to contact the 'on call' member of staff who might take some time to arrive and provide support.

The failure to provide sufficient numbers of staff to meet people's care and treatment needs, placed people at an increased risk of harm. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not able to tell us if there were enough staff on duty to meet their needs, however without exception people told us they like the staff that supported them especially [Consultant's name]. One person said, "I like all the new staff, things are much better now." Another said, "[Consultant's name] listens to me and sorts things out." Relatives told us that due to restricted visiting they had not been able to see their relations as often as they would have liked but didn't think the service was understaffed.

At the previous inspection we found the providers failure to establish and operate effective recruitment procedures placed people at an increased risk of harm. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvement had not been made and the provider was still in breach of regulation 19.

• People were not protected by safe recruitment procedures. The recently employed CEO started working at the service on 1st Feb 2021 and was in day to day charge of the service. References were not obtained for this person until July 2021 and at the time of the inspection the provider had not applied for a DBS. This person's application form stated they were a registered nurse; no check had been undertaken by the provider in respect of this person's NMC registration (Nursing Midwifery Council registration) or qualifications.

The failure to establish and operate effective recruitment procedures is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People received the correct medicines at the right time. Medicines were not used as a form of restrictive practice. The CEO had worked closely with their local NHS 'Trust' pharmacist to review people's medicines and implement the STOMP principles (stopping over-medication of people with a learning disability, autism or both) to only administer medicine that benefitted people's recovery or as part of ongoing treatment.
• We found people were not involved in this process and information about medicines was not available in an accessible format to allow people the opportunity to engage and take an active part in their care and support.
• Medicines were stored securely with access restricted to authorised staff. Staff followed systems and processes to safely administer and record the administration of people's medicines.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through Mental Capacity Act 2005 (MCA) application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home 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.

• Restrictive interventions were not regularly monitored, and the management team did not have a good understanding of DoLS. The consultant told us that five people living at the service would be prevented from leaving as it would not be safe for them to do so. Staff used mechanical restrictions in the form of a lap belt and bedrails with one person, to keep them safe from harm. We found there was no legal basis or framework in place to support these restrictions. DoLS application had not been made to the local authority.
• One person did have a DoLS in place, staff did not know if this contained specific conditions as this was not being monitored.

The provider had failed to ensure it was acting lawfully when depriving people of their liberties whilst receiving care. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people were not always supported to have maximum choice and control of their lives. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found not enough improvement had been made and the provider was still in breach of regulation 11.

• People were not supported to make decisions about their care and staff did not fully understand their roles and responsibilities under the Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Standards. This meant people who lacked capacity or who had fluctuating capacity did not always have decisions made in line with current legislation. For example, where restrictions had been placed on people to keep them safe, through the use of lap belts, bedrails or constant supervision, this was not recognised by staff as restrictive practice and people's capacity to consent to these arrangements had not been assessed nor had staff followed a best interests process.
• People's human rights were not always upheld as people were not always supported to have maximum choice and control of their lives.
• Where people had been identified as lacking capacity mental capacity assessments and best interest decisions showed a lack of knowledge and understanding of the principles of the MCA. For example, information contained within individual mental capacity assessments suggested that conclusions had been reached before the assessment had been completed. The decision to be made was not clearly recorded and at times included multiple decisions within one assessment process (not decision specific).

• Mental capacity assessments did not contain details to inform who was consulted or what their views were regarding decision. There was no recording of the person's views/preferences and wishes therefore there is no evidence of a person-centred approach or the involvement of the person in the process.
The failure to properly assess and record people's capacity and best interest decisions risked compromising people's rights. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's human rights were not upheld, staff did not support and empower people to be independent and have control over their own lives. There was a culture within the service of doing to and for people, which limited their choices, experiences and expectations. For example, there was limited information within people's care plans about how they could be supported to develop life skills and increase their independence.
• Throughout the inspection we observed staff making people drinks and snacks. We did not hear or observe people being actively supported or encouraged to do things for themselves.
• There was little evidence to show how people were involved in the development of their care and support, whilst we saw people's care records were regularly reviewed, this did not regularly involve the person or contain any information about their views, preferences or wishes. People knew they had a care plan but not been aware if they had contributed to its contents. One person said, "I think it's in the office." Another said when asked, "I haven't seen it."
• People were encouraged to use a range of healthcare services and supported to attend appointments with their GP', dentist, or optician. Each person had a 'Hospital Passport', which contained important information about them and their needs.
• We found staff did not always work together to ensure that people received consistent, timely, and coordinated person-centred care. For example, staff failed to seek medical advice for one person following a fall from bed, six days later it was discovered this person had fractured a bone. Staff failed to make or follow up referrals to healthcare professionals in a timely manner or to record and provide important information to one person's GP regarding seizure activity.
• People were not always supported to maintain a healthy balanced diet which met their needs. One person had been assessed as needing a modified textured diet. We found this person was not always having foods which were consistent with their assessed needs.
• Whilst the provider had made a number of positive improvements to people's living environment. The design and culture of the service still did not reflect best practice for supporting people with a learning disability, autistic people or people who have complex needs associated with their mental health. The CEO told us they were aware of the Right support, right care, right culture guidance, but could not give any tangible examples of any action they had taken as a result.
• We found the service was being developed in a way that was limiting people's opportunities to lead a normal life through the introduction of institutional practices. For example, a bar had been introduced to the dining room, which was to act as a cafe during the day and bar at night although we found no evidence this was taking place, as well as the introduction of a 'Tuck shop' where people could purchase drinks and snacks although they were limited to four items each. When asked, neither the CEO, consultant or staff were able to tell us why people were not being supported to go to a bar, a café or a shop to buy things for themselves.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they were able to input into choosing their food and planning their meals and we saw people had access to plenty of fresh fruit and vegetables. Staff told us people could access drinks and

snacks at any time. However, throughout the inspection we did not see, or hear people being encouraged to do so.
• People told us they were happy with the food provided and felt that their choices had improved. One person said, "I like the food," Another person said I can have what I want". Where people needed a specialised diet such as diabetic or gluten free, we saw this was being provided.
• Relatives told us this was one of the areas that had recently improved. One relative said, "One big improvement, drinks when they want, not at set times as before." Another said "They are allowed drinks and have a tuck shop once or twice a week, used to be just a cup of tea in the afternoon. They have a fruit bowel now for residents, which is positive."

At the last inspection we found the provider had failed to ensure staff had been provided with appropriate support, training and supervision. 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 not enough improvement had been made and the provider was still in breach of regulation 18.

• People did not receive support from staff who had received relevant training in order to ensure people's human rights were maintained. The provider monitored staff training on a training matrix which showed what training staff had attended. We found during our discussions with staff there were gaps in their knowledge, for example, in relation to infection prevention and control, fire, MCA, nutrition and hydration and safeguarding. None of the staff we spoke with, including the CEO and consultant, were able to describe the underpinning principles of Right support, right care, right culture guidance (choice, control, independence, inclusion) and how this might increase people's quality of life.
• None of the staff records we viewed contained any evidence of an induction or checks of staff competencies. We discussed what we found with the consultant who was unable to tell us if these staff had completed an induction or if there had been any formal assessment of their competences. Staff did receive individual and group supervision, although this was not seen as an opportunity to develop staffs' skills and/or knowledge or challenge poor practice and institutionalised thinking.

The provider failed to ensure that staff had the skills, competency and experience to ensure people's assessed needs were met. This was a continued breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

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

• People's basic human right to privacy and dignity and to be free from all forms of discrimination under the Equality Act 2010 was not always understood by staff or respected. Staff had a basic understanding of the Human Rights Act and Equality Act. In that people living at the service had the same 'rights' as everyone else, however this was not evident in their practice.
• Throughout the inspection we observed staff consistently left one person's bedroom door open or ajar even when this person was in bed. And on one occasion when they were receiving personal care. This practice was not challenged by the CEO, consultant, staff or the provider. All the people living at the service, staff and visitors were able to see into this person's room when they were sleeping.
• Although we observed many positive interactions between people and staff during the inspection, the language used by staff to describe the people they cared for within people's care notes, incident reports and on occasion when speaking with us, was infantilising, disrespectful, did not promote people's human rights or show they were valued as equal partners in their care. For example, one person had expressed a desire to join a dating agency. Staff told this person they needed to seek permission from their care manager.
• Staff regularly documented that people were being challenging or argumentative when describing people who were expressing their thoughts or opinions when they were emotionally distressed or upset.
• People were regularly told their behaviour was unacceptable and to go to their rooms to calm down or leave the lounge. Staff recorded in one person's notes, "Closed the door and left them to think about their actions". Another recorded, "What would your family member have to say or think about your behaviour".
• One staff member referred to one person as being, "Fed" meaning that the person needed help or assistance from staff with their meals to maintain a balanced healthy diet. Another referred to the same person as "She has LD", meaning the person has been diagnosed with a learning disability. This use of terminology is outdated and institutional and could cause offense.

The failure to ensure people were treated with privacy and dignity, and the failure to have due regard to any protected characteristics under the Equality Act 2010 is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were encouraged to make some decisions about day to day matters such as food and clothing. Staff told us people were supported to express their views and were involved as far as possible in making decisions about the care and support provided. We found more was needed to ensure people were truly involved and seen as partners in their care.
• Staff were not clear how they were engaging with people in understanding their rights, supporting them to have increased opportunities or make informed decisions and people did not have easy access to independent, good quality advocacy.
• People who were not able to communicate with us verbally, looked comfortable with staff and showed in their expressions and behaviours they enjoyed the company of the staff supporting them.
• Staff knew people well and understood what was important to them, be this their favourite movie, TV

program or pastime. However, we found more work was needed to increase people's expectations and ensure people were being fully supported to have equal opportunities within all areas of their lives and valued as individuals.

• People or their families told us that they received kind and compassionate care. People spoke highly of staff and consistently told us the service had improved. Comments included, "I like living here", "It has improved, they are doing very well", "It's my home and I like my keyworker and the staff they are my friends" and "It's alright, it's much better than it was, the staff are kind and doing a good job".

• Relatives provide mixed feedback; most relatives did not raise any concerns about the way their loved ones were cared for and felt that staff kept them up to date with changes in people's needs. One relative said, "[Staff name] communicates well and is very approachable." Another said, "Staff are very good. I have confidence in them. Amazingly satisfied with the care".

• One relative felt there were still areas that needed to be improved for example, in relation to people's dental and personal hygiene.

• People were supported to maintain links with those that are important to them. Relatives told us that through the pandemic staff had proactively kept them up to date with information and they had been able to speak to loved ones over the telephone, via video or through visits. One relative said, "If [person name] want to speak to us there has never been a problem they can just ring." Another said, "I keep in touch with them I have a good relationship with the staff."

• Feedback from healthcare professional described the service as being poor in their communications and the sharing of information. One healthcare professional told us they found it difficult to get hold of the CEO as they never call them back and they had requested some information numerous times but rarely received what they had asked for.

Requires Improvement

Is the service responsive?

Our findings

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

• Care and support did not always focus on people's quality of life outcomes or meet best practice. Some of the care records we viewed were personalised, detailed and provided staff with information and guidance they needed to care for people safely and in a consistent way.
• Some care and support plan's lacked details of the support people needed to meet their health care needs, develop life skills, increase their independence, or maintain and develop relationships. For example, one person was experiencing regular seizures, this information did not form part of the person's care and support plan.
• Another person was keen to join a dating agency and had been asking staff for help and support since Feb 2020. This information did not form part of this person's care plan nor were there plans in place to support this person either through the use of equipment or advocacy.
• Whilst people had a range of assessments in place, support was not always provided in line with these. For example, some people experienced periods of emotional distress and the provider developed personal behavioural support plans. We found these were not being followed by staff.
• People's communication needs were not always being met. One person had limited speech and used Makaton to communicate their individual needs and preferences. Whilst this person did have a communication care plan this did not provide any information about the Makaton this person used. Staff we spoke with did know this person well and were able to communicate with them.
• Support plans were not accessible to people and the provider had not developed information an accessible format
• Staff were not provided with a basic level of communication or Makaton training

The provider had failed to ensure people's care was appropriate, met their needs and reflected their preferences. This is a breach of regulation 9 (Person centred care) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

• Other people's care records did contain information on people's preferred method of communication and whether they required any communication aids, such as glasses or hearing aids.
• Some people were unable or found it difficult to communicate verbally, due to their autism or learning disability and communicated with the assistance of pictures, signs and symbols.
• Support plans included a list of people's known hobbies/interests. However, due to the impact of COVID-19 national restrictions, we have been unable to fully assess how the provider was supporting people to lead normal confident and empowered lives which promoted their independence.
• The consultant explained how they worked with people to ensure they were not socially isolated, and they described the difficulties that had been placed on the provider and people due to the government restrictions. This had meant that due to the national lockdown people had not been able to fully participate in community life. However, records showed, where possible and in line with government guidance, some people had been able to visit family, go shopping or to places they enjoyed such as the local water front and Zoo, One person said, I don't like stopping in, it was nice to be able to go out."

• As well as trips out, staff encouraged and supported people to engage in a variety of activities from theme night and tasting sessions to getting involved in the world cup. The consultant told us they had recently purchased a couple of chickens and developed the garden/patio area so people could get involved in the planting of vegetables or relax in the service's new Barbecue area. One person said, I feel more involved now, I enjoy feeding the chickens and helping in the garden. Another was keen to tell us how their name had been chosen for the bar/ café.
• The provider had also put together a newsletter, although people and their relatives told us they hadn't seen it. One person said, "I don't know". Another said, "I haven't seen it". Five of the six relatives told us they were not aware of it and one said they thought it would have been given to a social worker.
• The provider had a system for responding to concerns and complaints. No complaints had been received. The provider was confident that staff would treat all concerns and complaints seriously, investigate and share the learning with the whole team. People told us they would speak to the provider or key worker if they were unhappy. One person said, "I would tell [Keyworkers name], they're my friend. Another said, "I would go straight to the top."

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 previous inspection we found systems were either not in place or robust enough to demonstrate the service was being effectively managed and there was a clear lack of oversight which placed people at an increased risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

• The service did not have a manager registered with the Care Quality Commission at the time of the inspection. The CEO told us they had submitted an application to register but we had not been able to locate this application when we checked.
• The providers oversight and governance of the service was ineffective in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe, effective, caring and responsive sections of this report.
• Following the inspection in October 2020 the provider engaged the services of a consultancy who had assumed day to day management responsibilities for New Redvers. The provider confirmed they did not undertake any due diligence or background checks of the consultancy or its employees, prior to their engagement and employment to assure themselves they had the necessary qualifications, competence, skills and experience.
• Leaders did not have the skills, knowledge and experience to perform their roles. The culture of the service did not reflect best practice guidance for supporting people with a learning disability and/or autistic people. Neither the provider, CEO, consultant, or staff fully understood Right support, right care, right culture guidance published by CQC, or how the underpinning principles could be used to develop the service in a way which supported and enabled people to live an ordinary life, enhanced their expectations, increase their opportunities and value their contributions.
• We found staff use punitive practices as a way of controlling people's behaviour.
• Institutionalised practices, in the form of a bar and tuck shop had been introduced and described by the CEO and consultant as evidence of outstanding care. Language used by staff was disrespectful, devaluing and people were treated in a way which compromised their human rights.
• People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs. All of which created a closed culture, which increased people's dependence on staff who had limited understanding of how to support people in a way which upheld their human rights. The CEO and consultant seemed to be unaware of the culture within the service and had not recognised this as something that needed to be addressed/challenged.
• Systems and processes to monitor the service were not undertaken robustly. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. Issues included concerns with regards to safeguarding, recruitment, staffing, training, infection prevention and control, management of risk, nutrition and hydration and MCA.

• Governance processes did not help to keep people safe, protect their human rights and provide good quality care and support. For example, accident and incidents did not reflect the levels of incidents taking place or that appropriate action had been taken. This meant they could not be relied upon as a source to measure quality and risk.
• Poor judgements and decision making potentially placed people at the risk of harm. For example, in relation to infection prevention and control, the management of risk or seeking external advice and support.
• The provider had not ensured the staff understood the principles of the MCA. This lack of knowledge and understanding risked compromising people's rights.
• Following a review of the providers website we found they were advertising 'home care' services that did not fall within the scope of their current registration. We brought this to the attention of the provider who gave us assurance that they were not providing a regulated activity to people within their own home.

The provider had not ensured the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and their relatives continued to have confidence in the provider and told us the service was well managed. One person said, "I like them both", meaning the CEO and consultant. Another said, "It's much better now". Relatives comments included; "Yes I think it's well led", "I think they are getting there", "[Consultant name] is very approachable", and "[Consultant name] keeps me informed of what going on."

At the last inspection, we found the provider had failed to notify the Commission of significant events, which had occurred in line with their legal responsibilities. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4). At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

• The provider had not notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This included the notification of safeguarding concerns. When asked the consultant told us they were not aware that they needed to be reported and had not been directed to do so by the CEO or provider.

This was a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

• The provider did not apologise to people and those important to them, when things went wrong. The provider had failed to be open and transparent about two notifiable safety incidents that involved a person who fell from bed in November 2020 and May 2021. This person's relative said, "It was rather 'confused'. I found out when [Person's name] went into hospital for another procedure. I still do not know the outcome, and I have not received a report."

The failure to be open and transparent about notifiable safety incidents that occurred in respect of a person during the provision of a regulated activity was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• On 30 October 2020, we undertook an inspection of New Redvers Residential Home and rated the service as Inadequate overall. As part of this inspection we undertook a review of their website https://dc2000ltd.co.uk which is maintained by the provider and identified the provider had failed to display

the their performance rating referred to above as is required.

The failure to display a rating of your performance is a breach of Regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to inform the Commission of changes to their statement of purpose within the required time frame. This was a breach of regulation 12 (Statement of Purpose) of the Care Quality Commission (Registration) Regulations 2009 (part 4).