Four Care Plus Limited

Prospect House

Inspection report

31 Drury Lane
Altofts
Normanton
West Yorkshire
WF6 2JT

Tel: 01924896620
Website: www.fourcareplus.co.uk

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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: Prospect House is a residential care home that was providing personal care to seven people with a learning disability at the time of the inspection.

People's experience of using this service:
The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; lack of choice and control. Staff often made decisions on people's behalf but did not follow a formal decision-making process or record the decision. For example, staff made decisions autonomously about when people had snacks rather than following person centred guidance. Staff asked people to add their meal preferences to the menu but then cooked different meals.

People were not safe. Risks to individuals were not assessed and appropriately managed. Staff were using restraint but national guidance around safe restrictive interventions was not followed. Incident forms were not reviewed in a timely way by the management team. Medicines were not managed safely. Lessons were not learned when things went wrong. Some people did not receive the appropriate staffing support even though they had specific funding. The recruitment process was not always followed robustly. Some areas of the home looked clean, but others required deep cleaning.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Staff received training and supervision, but this did not equip them with the skills required to do their job well. People told us they enjoyed the meals and chose what they wanted for breakfast, snacks, light meals and supper. Records showed people had been seen by health professionals but there was no overview of people's health and staff could not find out when people had last attended some appointments. People lived in a pleasant environment and had personalised rooms and access to a range of communal areas.

Staff and management did not always pay attention to detail, for example, laundering of clothes. People looked well cared for when we visited but relatives told us this was not always the case. Examples of people making choices and caring staff practices were seen on both days of the inspection. People enjoyed the company of staff who supported them. Staff explained how they ensured people had privacy, for example, giving a person time alone during personal care. However, listening monitors were sometimes used inappropriately which did not provide people with privacy.

People did not always receive opportunities to engage in person centred activities. Activities were not well planned although people told us they had enjoyed various outings. People's support plans contained a lot of information but did not always reflect their needs. The provider did not have an accessible system for identifying, receiving, recording, handling and responding to complaints.

The service was not well led. The provider's quality management systems were not effective and did not

identify areas where the service had to improve. The registered manager and provider did not demonstrate they understood their responsibilities and accountability. Opportunities for people who used the service, their relatives and staff to engage in the service varied.

The service has a history of providing poor quality care; it has only been awarded ratings of requires improvement or inadequate. We have previously met with the provider to discuss our concerns about the service.

Rating at last inspection: Requires improvement; not in breach of regulation (Published date: 26 May 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Follow up: We referred our concerns to the local safeguarding authority and asked the provider to send us evidence of improvements and action points. This was used when decisions were made about our regulatory response.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

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

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

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 always 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

Prospect House

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
On 1 May 2019, the team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 21 May 2019, two inspectors carried out the inspection.

Service and service type:
Prospect House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Prospect House can accommodate up to seven people.

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:
The inspection was unannounced.

What we did:
We reviewed the information we had received since the last inspection. This included notifications sent by the provider and information of concerns that had been shared with us. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This is called a Provider Information Return (PIR) and helps support our inspections. They sent us this information in March 2019.

During the inspection we spoke with everyone who used the service, four relatives, six staff, the registered manager and area manager. We gained limited information from some people who used the service about their experience of living at Prospect House because of the different ways they communicated. We looked around the service and observed how people were being cared for and supported at meal times.

We reviewed a range of records. These included three people's care records and four staff files. We also looked at training and supervision matrices, records of accidents and incidents, audits, and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection this key question was rated 'requires improvement'. This was because controlled drugs were not stored appropriately, and lessons were not learned when incidents occurred. At this inspection the rating for this key question deteriorated.

Using medicines safely

- Medicines were not managed safely because people did not always receive their medicines as prescribed.
- Medicine administration records were not always fully completed; gaps where staff had not signed were not explored.
- Just before the inspection, one person had received the incorrect dose of medicine over two days; this was because staff had not followed instructions on the medication administration record. A member of the management team said this did not have any significant impact on the person and it was reported to the local safeguarding authority.
- One person had very sore patches of skin and were clearly in discomfort. They told us it was very painful. Bandages and two types of cream were prescribed to protect the skin. However, the service had no bandages in stock and staff did not know in which sequence to apply the creams. This meant the person did not receive appropriate treatment and staff had not followed safe medicine practice. We asked the management team to take immediate action and report this to the local safeguarding authority.
- One person was prescribed a medicine that stated on the medication administration record it should be taken either one hour before or after other medicines. The person received the medicine 20 minutes after other medicines. This meant the person did not get their medicine as prescribed. A protocol to guide staff was in place but this did not make any reference to the time gap between this medicine and other medicines.
- Staff did not know where to apply a topical cream which was prescribed to one person. The topical medication administration record did not have directions and no other information was available. The cream was prescribed twice weekly.

- The lack of managing medicines appropriately meant people were not safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff who supported people with their medicines explained what they were doing, and ensured people had water and took their medicines. Two staff carried out all administration tasks to help reduce the risk of errors.
- Daily checks were completed to make sure medication stock was correct.
- Some protocols such as guidance for administering paracetamol were detailed and person centred.
- Medicines were examined on day one of the inspection. The provider had taken some steps to improve

systems and processes when we returned on day two; staff had received additional training and people had medicine cabinets installed in their room.

Staffing and recruitment

● The provider did not have an effective system in place to make sure people received appropriate staffing support.

● Everyone was funded for some one-to-one staffing although the hours varied for each person. Some people received the correct number of one to one staffing hours, but others did not. For example, one person was funded for 10 hours per week. The person's individual records showed they sometimes went out on an individual basis with staff, but this did not equate to the funded hours. Records set up to show when people had one to one support were incomplete.

● Feedback about the staffing arrangements varied. One person said, "They are always short staffed, I keep telling them, but they don't listen." A relative said, "I think there's enough staff, I've not seen any problems."

● Some staff told us they had time to give people the support they needed. Some staff told us they did not have time to complete all the tasks that were allocated to them.

● Concerns were raised about the high turnover of staff. One person said, "It changes; sometimes it's all right for a while, and staff leave and then we're back to agency staff. It is always happening." Three relatives said they were concerned. One said, "There is too much staff change over, they get rid of all the good staff and bring in new staff that they don't really know [name of person]."

● A monthly rota was used to plan the staffing arrangements. Staff received their rota only one day before the monthly rota commenced. This meant staff had very limited time to plan for their shifts. Staff told us this was inconvenient and caused problems when trying to sort cover.

● The lack of sufficient staff meant people were not safe. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A listening monitor was used during the night and kept on the landing. One person's risk assessment stated it was used to ensure 'all service users were kept safe throughout the night due to limited staffing'. The area manager said two staff were on duty during the night, enough to monitor people who were upstairs, so the monitor would be removed.

● The provider confirmed their staffing arrangements met the funded hours. They acknowledged staff were not always allocated effectively and had taken action to address this.

● Some staff checks were completed before staff commenced employment such as criminal record checks. However, checks around previous employment and conduct during employment were not always completed One member of staff who commenced in the last 12 months did not provide a full employment history. References were not available for another member of staff. The registered manager said they had received two telephone references and records were made at the time, but these were not located during the inspection; copies were sent via email after the inspection.

● The management team said they would ensure all checks were completed robustly in future.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

● Risks to people were not appropriately assessed, monitored and managed. People had assessments, but these were not clear and did not ensure risks were managed. For example, one person's assessment stated they 'required a structured activity regime that keeps them busy/engaged and this should reduce the likelihood of behaviours occurring'. The person did not have an activity programme. Another person had a notelet stuck on the front of a risk assessment that stated part of the guidance was no longer followed; there was no review of the assessment or information to show what was being done instead.

● Risk management was inconsistent and sometimes limited people's control over their lives. One person asked why they could not sit in the front seat of the car when they went out. They were told this was because, "It's been risk assessed." However, their mobility support plan stated they could sit in the front or back seat of the car.
● Charts for monitoring how much people had to drink and when they went to the toilet were only partially completed which meant the records did not provide an accurate overview or enable staff to monitor risk.
● The provider's information return showed they were using restraint on a frequent basis. However, incident records showed they were not following national guidance around restrictive intervention because post-incident reviews and debriefs were not held. This meant risk was not monitored and lessons were not learned when incidents occurred where restrictive interventions were used.
● Incident forms were not reviewed in a timely way; twenty three were waiting for a member of the management team to assess.
● One person had 24 incident reports which covered a four-week period; 23 stated there had been no lessons learned.
● Before the inspection a concern was raised that there had been a period where the service vehicle's MOT had expired. The provider acknowledged this and stated they had introduced a better system for ensuring this did not reoccur.

● The lack of identifying, assessing and managing risk meant people were not safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Checks had been carried out by staff and external contractors to make sure the premises and equipment were safe.

Systems and processes to safeguard people from the risk of abuse
● The provider had reported a number of allegations of abuse to the local safeguarding authority and CQC; these showed the provider had responded appropriately. However, two incidents of verbal abuse had not been reported even though the safeguarding policy stated abuse included 'threats of harm' and 'verbal abuse'. This meant we were unaware of all significant events and did not have relevant information about how the provider had responded.
● Staff understood safeguarding and whistleblowing procedures and their responsibility for reporting concerns. All staff received safeguarding training.

Preventing and controlling infection
● On day one of the inspection some areas of the service looked clean, but others required deep cleaning, for example, one toilet had dirty/dusty skirting board, and dust and grime around the toilet base. Skirting boards on stair cases and corridors were dirty and dusty. On day two of the inspection most areas which were dirty had been cleaned.
● No odours were noted throughout the service.
● Bathrooms and toilets were stocked with equipment so appropriate hand hygiene procedures could be followed.
● On day two of the inspection the registered manager showed us they had started devising a cleaning schedule which they said would be implemented in the next few days.

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At our last inspection this key question was rated 'requires improvement'. This was because the provider was continuing to develop approaches to ensure people's rights and choices were promoted and improve people's care records. At this inspection the rating for this key question deteriorated.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People were not appropriately supported to have choice and control of their lives because the key principles of the MCA were not applied.
- Some decisions were made on people's behalf and done in consultation with others. However, staff often made decisions and did not follow a formal decision-making process or record the decision. For example, on day one of the inspection one person's drinks were limited but there was no evidence this was done in the person's best interest or in line with the expectations of legislation. One member of staff said drinks were limited to every hour another staff said every 30 minutes. The person's support plan only stated staff should be 'vigilant' when the person was drinking. Another person had the sink tap in their en-suite removed. Staff said this was to help manage behaviours that challenged but there was no reference to this in any of the person's care records. The management team could not show when the tap was removed; views on the length of time varied from one month to one year.
- People had snacks such as chocolates, crisps and biscuits but on day one of the inspection these were kept in individual lockers in the activity room. Staff kept keys for all the lockers on a keyring and access was restricted. People did not have assessments or support plans to show the restrictions were reasonable or person centred. One person entered the office and grabbed a chocolate. Staff said they usually had snacks from their locker on an evening. However, this was not agreed through any support planning process which meant staff made decisions independently rather than following person centred guidance. On day two of the inspection the registered manager had started taking steps to address the issues raised on day one. They had replaced the tap and the lockers had been removed from the activity room.

● Failure to meet the requirements of the MCA meant people's rights were not protected. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not have the required skills and did not recognise poor practice.
● Staff lacked knowledge around how to support people with behaviours that challenged. They completed training, but this did not equip them with the skills to fully understand the different intervention techniques. Staff recorded different level intervention techniques they used on incident forms but were unable to explain what these were.
● Staff did not always have a basic understanding of people's needs. A senior member of staff was unable to say if the person they were supporting had autism.
● Staff did not always understand people's human and legal rights.

● The lack of appropriate support meant staff were not equipped to carry out their role competently. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff met with their line manager after they had commenced employment during their probationary period. This showed the management team spent time finding out if staff were settling in. Staff that had worked at the service on a longer basis also met with their line manager and discussed their role.
● Staff completed on-line training in a range of areas; records showed these were completed when staff started work and refreshed at set intervals.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective and timely care: Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● A standard support plan and risk assessment format was used to assess and identify people's needs. However, this was not always effective because the quality of information about people's needs varied and staff did not always follow national guidance. For example, around managing behaviours that challenged.
● People did not have health action plans and staff did not maintain records of when people needed health reviews. Staff were unable to readily access information about when people had last seen some health professionals, for example, dentist. This meant people's health needs could be overlooked. The management team agreed to carry out a review of people's health needs and arrange appointments with health professionals where appropriate.

● Failure to follow national guidance and the lack of health care planning meant people's needs were not appropriately met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although there was no clear overview of how people's health needs were met, care records did show health and social care professionals were involved in people's care. For example, one person had recently seen their GP and a practice nurse.
● One person told us they went with staff to the doctors when they were poorly. Another person told us they sometimes spoke with their social worker.

Supporting people to eat and drink enough with choice in a balanced diet
● Menus for the main meal of the day were developed with people who used the service, but these were then not consistently followed.

● The service had a pictorial food folder which listed a good variety of meals. One person showed us the folder and told us they selected what meals they wanted to add to the menu. They said other people also chose their preferred meals. A member of staff said everyone contributed to the menus which were developed monthly. However, other records showed different foods to the menus were cooked and served. The deputy manager could not explain or provide any information to show why the menus had not been followed. This meant people's choices had not been respected.
● People told us they enjoyed the meals and chose what they wanted for breakfast, snacks, light meals and supper. At lunch people selected what they wanted to eat, and then staff supported them to make their meal.
● On day two of the inspection, the registered manager said they had reviewed the system for planning meals and would be monitoring this closely to make sure the menus were followed.

Adapting service, design, decoration to meet people's needs
● People lived in a pleasant environment. Areas were decorated to a good standard.
● There were different communal areas for people to spend their time such as sitting rooms, an activity room and a dining area; these were well used. The activity room was equipped with craft material but also used for people to keep their coats, shoes and bags. A vacuum cleaner was stored in the corner. The additional items made the room look cluttered and space was limited.
● Domestic kitchen facilities provided people with opportunities to make drinks, and prepare and cook meals.
● People could access outdoor space although the enclosed garden looked unkempt and had not been recently tidied. Since the last inspection a decking area had been built.
● Everyone had individual accommodation with en-suite facilities. People were encouraged to personalise their rooms.
● A large fixed cushion from one settee was missing. A member of the management team said it was removed because it had been damaged and would be replaced

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 did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection this key question was rated 'good'. At this inspection the rating for this key question deteriorated.

Respecting and promoting people's privacy, dignity and independence: Ensuring people are well treated and supported; respecting equality and diversity

- Staff did not always understand the importance of people's human rights. They did not always take people's privacy and preferences into account.
- Listening monitors were used. Staff said these should be switched off during the day for privacy reasons. However, this practice was not followed. On day one of the inspection, a private conversation between a person who used the service and a member of the inspection team could be heard in the office. Staff said the monitor was kept switched on when the person was in their room and at risk of seizures. The management team said they would review the use of monitors.
- Information in support plans was sometimes contradictory. For example, one person's sleeping support plan said they were to be asked if they wanted their door locked but they held their own key and their door locked automatically. The plan also stated they were only allowed water during the night. The registered manager said there should be no restriction and agreed to review the person's support plan.
- Staff shared concerns about the system in place for planning and arranging activities. They explained weekly activity planners should be used for a month. For example, if it stated cinema on a Monday that would be every Monday during the same month, even if there was no film the person wanted to see.
- Feedback was received from relatives that the service failed to pay attention to detail, for example, laundering of clothes, making sure people looked well-presented and keeping outdoor areas tidy. A relative told us they had met their relative in the community with their support worker and they were wearing odd shoes.

- Failure to provide person centred care and support meant people's needs and preferences were not met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care records contained some good person centred information, which included, 'what people admire and like about me' and 'what makes me happy'. People's preferences were sometimes recorded and met. For example one person's support plan stated they enjoyed music and their daily records confirmed this was offered.
- Staff provided examples of how they promoted privacy, which included where appropriate standing outside the bathroom when people were showering and using the toilet. One person was observed enjoying time alone in the enclosed garden. Staff were vigilant but made sure the person had space.

● Examples of caring practice were seen on both days of the inspection. People enjoyed the company of staff who supported them. Some people enjoyed banter with staff and others they lived with.

Supporting people to express their views and be involved in making decisions about their care
● People had decision making and communication support plans. However, these were not always effective or used by staff to help them understand how people made their views known.
● Examples of people making choices were seen on both days of the inspection. For example, people were asked to choose what they wanted to eat and drink.
● Staff supported one person to purchase a mobile telephone. Communication was good; the person was consulted and updated about progress in obtaining the correct funds. Staff and management experienced some complications financing the purchase; they persevered and resolved the issue. The person was very happy with the outcome.
● One person told us they were unhappy living at Prospect House and did not feel listened to. They said they had spoken about moving but nothing had happened. A member of staff shared concerns that the person consistently expressed they wanted to live in a different setting. The registered manager said they had regular communication with the person's social worker and options were being considered.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

At our last inspection this key question was rated 'requires improvement'. This was because the provider was continuing to improve people's care records. At this inspection the rating for this key question deteriorated.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control: End of life care and support.

- People's needs were not always identified, recorded, and highlighted in support plans.
- Support plans contained a lot of information, but did not always reflect the person's needs. One person's support plan stated they could have one beer. Staff and management were unclear about the reasons only one beer was allowed. One member of staff said they thought it was a decision that was made two years ago. However, we established they were prescribed a medicine that clearly stated alcohol should not be consumed. Another person had a support plan for cutting nails and hair. This stated if the person received 'any lacerations or abrasions during the process of hair or nail cutting follow first aid training'. There was no information about why the person might receive lacerations or abrasions or where they had their hair cut. A relative raised a concern that the person did not get appropriate support to get their hair cut and, in the past, had looked unkempt.
- People did not always receive opportunities to engage in person centred activities. One person was observed wearing headphones and singing loudly; this lasted the whole day of the inspection. No one offered the person an alternative activity. An incident form stated boredom had been a trigger to recent behaviour. At no time did staff consider how the continuous singing impacted on others.
- Another person sat for long periods with very little interaction on both days of the inspection.
- Activity planners were displayed in the office. However, these were three weeks out of date.
- Activity planners were not followed. For example, one person's plan stated they should go to a water park on a Thursday afternoon throughout May. However, the daily notes showed this had not happened. There was no explanation as to why the activity planner not followed.

- The lack of planning care and support meant people's needs were not identified and met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Daily records were detailed and provided information about people's daily events such as times for getting up, personal care and activities.
- People told us they had been on various outings. Comments included, "I've been to the railway museum at York", "I went for a day trip to the seaside" and "I like going out to the shopping centres".
- People had information in their care records about their preferences around ageing, illness and end of life.
- The service had some pictures and photographs to help people understand information. Support plans provided details of how people's communication needs should be met.

Improving care quality in response to complaints or concerns

● Concerns were not always responded to and investigations did not always drive improvements.

● The registered manager and provider could not locate any records of complaints. The area manager said the complaints folder had gone missing and they did not keep an electronic copy of complaints.

● In the provider information return the provider said no complaints had been managed under their formal complaint's procedure in the last 12 months. The registered manager confirmed this was still correct at the time of the inspection. However, CQC had shared complaints with the provider and was aware other complaints had been made directly to the provider. This meant complaints were received but not recognised as formal complaints.

● Before the inspection concerns were shared with the provider which related to the standard of care, staffing arrangements and the overall management of the service. The management team responded to the concerns and gave assurance that appropriate systems were in place. For example, concerns were raised about healthy eating. The provider said monthly meal planning was in place. However, the inspection findings showed meal planning was not effective.

● Records showed a member of staff had raised concerns with the management team in March 2019 that colleagues were not always carrying out tasks such as cleaning the environment. There was no information to show this was dealt with. The registered manager acknowledged similar issues had been raised at the inspection and said they would respond to the member of staff.

● Two relatives said although they had raised concerns improvements were not made. One relative said, "I have no trust in the management at all, I'm tired of hearing my own voice in complaining, with nothing changing." Another relative said, "I have no problem complaining, I know what's right and wrong, I just wished they would listen."

● A relative told us they had raised a concern because a member of staff was using their mobile phone when out in the community with their relative. They said this worried them, so they reported it to the registered manager who said, 'they would sort it'. The relative told us they had not heard back from the registered manager.

● The complaints procedure was displayed near the entrance of the service; this referred to the previous registered manager who left their position in August 2018.

● Failure to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints meant improvements were not made to the quality and safety of service provision. This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our last inspection this key question was rated 'requires improvement'. This was because the provider needed to demonstrate they could maintain an effective monitoring system. At this inspection the rating for this key question deteriorated.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care.

- The service has a history of breaching regulations. In 2016, the service was rated as requires improvement. In 2017, the service was rated inadequate; issues related to governance arrangements, failure to meet requirements of the MCA, staffing, person centred care, safe care and treatment and recruitment practices. These are the same areas of concerns identified at this inspection. In 2018, the service had made improvements and was no longer in breach of regulations but still needed to improve their systems further.
- Quality management systems were not effective. There was a lack of checking and monitoring by the registered manager and the provider. Significant concerns were identified throughout the inspection process; these had not been highlighted through their auditing and monitoring processes.
- The service was not well led. The registered manager and provider had poor oversight of the service and demonstrated a lack of awareness of the issues which we have highlighted of concern at this inspection.
- The registered manager and provider said they were unaware people's menu choices were not being cooked and served. This meant their system was not effective for ensuring people's preferences were respected and monitoring if people had a balanced and varied diet.
- The registered manager said they were unaware snacks were being stored in lockers in the activity room. They described the practice as disgusting and said, "This is a practice I stopped when I first started. I had explained to people this should not happen."
- Systems and processes did not drive improvement. The registered manager and provider were not always responsive. There was a prolonged period between incidents and incident report forms being reviewed by the management team. Staff routinely wrote 'no' or 'none' in the lessons learned section.
- The service did not gather information or have an overview of incidents. This meant they did not have systems in place to look for trends and themes.
- The service was not well organised and the management team struggled to locate documents and key records. This included the staff rota, complaints' records, staff references and menus.
- Initially staff could not locate the menu which had commenced two days before the inspection. Seniors in charge of the shift said they did not know if it had been completed.
- The staffing rota could not be located; this was found in the management team's office but had not been

shared with staff. Staff did not know what they were working the following day. Staff were concerned because they had to make prior arrangements to facilitate working shifts but had not had notice to do this.
● The service has a history of breaching regulations. In 2016, the service was rated as requires improvement. In 2017, the service was rated inadequate. In 2018 the service was rated requires improvement. Previous issues have related to governance arrangements, failure to meet requirements of the MCA, staffing, person centred care, safe care and treatment and recruitment practices. These are the same areas of concerns identified at this inspection.

● The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.
● Staff views on how well they could engage in the service varied. Everyone said they discussed the service on a daily basis, for example, at handover and during the shift. They said they discussed the service with the deputy manager who was responsible for supervising staff.
● Some staff said they did not get opportunity to attend staff meetings because they were either on duty or it was their day off.
● Staff meetings minutes showed two meetings were held in January 2019; one for all staff and one for senior support workers. Seven staff attended the general meeting and three attended the senior meeting. Topics discussed included health and safety issues, safeguarding, sickness procedure, mobile phone policy. At the senior meeting it was recorded that there were no restrictions to anyone having drinks at any time, however, this practice was not implemented. A team meeting was held in March 2019 although minutes of the meeting were not available.
● The registered manager said surveys had recently been sent to relatives and were being sent to other professionals and staff; at the time of the inspection one relative survey had been returned. The registered manager said once surveys were returned the responses would be analysed.
● In the PIR the provider provided examples of how they worked in partnership with others. This included working alongside a dietician and an epilepsy nurse.