Lovestar Limited

Homeleigh Residential Care Home

Inspection report

The Bungalow
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28 October 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Homeleigh Residential Care Home is a small care home that provides accommodation and personal care support for up to five adults with learning disabilities and or autism and who may have enduring mental ill-health. There is a communal lounge, kitchen, bedrooms and small garden area in the main home/premises with four people living there and another smaller separate unit opposite the main home. This has a small kitchen, lounge, bathroom and two small bedrooms. One person was living in the smaller unit. At the time of our inspection the service was fully occupied supporting five people across the two sections of the home.

At our previous inspection on 23 October 2018 we identified a number of breaches of regulations of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had failed to make the required improvements in all areas identified at our last inspection. At this inspection we found there had been a further deterioration in the quality of the service with further breaches of regulations identified.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

People's experience of using this service and what we found
Feedback from people and their relatives were mixed and relatives did not always feel their family members were safe and well supported. People were not protected from avoidable harm. The provider continued to fail to report and respond appropriately and in line with safeguarding policies and procedures, where incidents had occurred causing potential harm to people. Policies and procedures for safeguarding adults and children were not up to date or robust.

Restraint, seclusion and segregation practices were unlawful used within the service. People consent was not always sought and the provider failed to assess capacity where appropriate and work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Risks to people's health, well-being and safety continued to be inadequately identified, assessed and reviewed to ensure people's safety and well-being. Arrangements to deal with foreseeable emergencies and to maintain the safety of the premises were not always robust or routinely completed in line with regulations and best practice. Accidents and incidents were inconsistently and inappropriately recorded and there was no analysis or monitoring tools in place to manage, monitor or learn from accidents and incidents.

People's legal rights were not protected because staff did not follow or act in accordance with the MCA and DoLS. The registered manager failed to notify the CQC that authorisations were in place as required by law.

People's needs were not always reassessed or reviewed when changes in their needs occurred and this required improvement. People were not always supported to maintain a balanced diet and or were offered choice of foods. Staff knew the people they supported, however they did not always have or display the skills and knowledge to meet people's needs appropriately in line with best practice.

The outcomes for people using the service did not reflect the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. Aspects of staff practice was not always caring and staff did not always interact or communicate with people effectively. People were not always supported to make their own decisions or to be involved in planning and reviewing their care. People's privacy, dignity and independence was not always respected or supported.

Care plans were not always up to date and reflective of people's needs and wishes. People did not always receive personalised care and the provider failed to maintain accurate, complete and contemporaneous records. The registered manager and staff lacked knowledge and understanding of the accessible information standards. The provider failed to produce information and documents in a format that met people's needs such as easy to read assessments, care plans, service user guides and the complaints procedure. The provider failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.

The provider failed to ensure safe management oversight, to seek and act on feedback, assess, monitor and improve the quality and safety of the service. The registered manager did not fully understand their responsibility under the duty of candour and were not always open and honest during the inspection. They failed to take responsibility when things went wrong and did not keep their knowledge and understanding regarding best practice, or the changes in fundamental standards and regulations up to date.

Medicines were managed, administered and stored safely. There were enough staff to meet people's needs and recruitment systems were in place to reduce identified risks. People were protected from the risks of infection and the home environment appeared clean and well maintained. People's physical, mental and emotional needs were assessed and documented in their plan of care. The service was adapted in some areas to meet people's needs and the garden and outside space was accessible to some people. People were supported by staff to access services such as, leisure activities to meet their needs and interests.

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

Rating at last inspection
The last rating for this service was requires improvement (published on 23 October 2018) and there were three breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found there had been a further deterioration in the quality of the service with continued and further breaches of regulations identified.

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

Enforcement
At this inspection we identified continued breaches and new breaches in regulations. There are seven

breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals are added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures.

This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Homeleigh Residential Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by one inspector and an inspection manager.

Service and service type
Homeleigh Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection site visit took place on 24 and 28 October 2019 and was unannounced.

What we did before the inspection
The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people.

We reviewed information we had received about the service since the last inspection. This included reviewing the provider's action plan we had asked for following our last inspection when we identified breaches of the regulations. We sought feedback from professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We met and spoke with everyone using the service and one visiting relative to seek their feedback on the service. People living at the home had varying levels of communication and some people were unable to share their views and experiences, so we therefore used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing the support provided to people in communal areas, at meal times and the interactions between people and staff.

We met and spoke with the registered manager, deputy manager and three support workers. We reviewed a range of records including four people's care plans and records and three staff recruitment, training and supervision records. We also reviewed records used in managing the service for example, policies and procedures, monitoring records and minutes of meetings.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as 'Requires Improvement'. At this inspection this key question has now deteriorated to 'Inadequate'. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At our last inspection people were not safeguarded against the risk of abuse. Potential safeguarding concerns were not acted on and reported as appropriate and in line with best practice. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● People were not protected from avoidable harm. The provider continued to fail to report and respond appropriately and in line with safeguarding policies and procedures where incidents had occurred, causing potential harm to people using the service.
● For example, we found references in people's daily notes documenting examples of displayed behaviour that staff may find challenging. We saw that one incident involved the use of restraint of an individual by a member of staff. The use of restraint had not been assessed and following the incident risk assessments and guidance for staff had not been fully reviewed to manage the behaviour safely. We spoke with the registered manager about these incidents where people may have suffered harm. They failed to acknowledge the potential harm which may have been caused and had not discussed or reported the incidents to the local authority safeguarding team.
● There was a lack of clear guidance for staff on how to support people who displayed behaviour that they might find challenging. Staff training records showed that staff were not provided with appropriate training to support people safely. For example, although staff had received training in challenging behaviour there was no assessment of staff competency in completing breakaway techniques, even though the provider's policy stated these should be used when needed. This placed people at possible risk of harm.
● The provider and staff were using restrictive practices within the service which were unlawful and not in line with best practice. For example, one person told us how they were restricted and were required to be back at the service by a set time at night as this was their curfew. They said, "I would like to be able to stay out later and go to bed later but they [staff] don't allow me." We drew this concern to the registered manager's attention who stated this was part of the person's community treatment order (CTO). We looked at the person's CTO and the conditions that had been set in place. There were no conditions documented stating that the person was to return to the service by a set time each evening on the CTO.
● We saw another person was segregated and placed within an external unit opposite the main home away from other people using the service. They were unable to leave the unit independently and we observed that there were several occasions when they were alone within the small unit with no staff present which could pose a risk of harm. We discussed our concerns about the person being secluded with the registered

manager. They told us that [resident] was better placed there as they 'could be noisy which disturbs others.'
● We observed that people were restricted and discouraged from being independent and or free to do things within their home. For example, we saw the television remote control was removed from the lounge area by staff so that people were not able turn the television on or off or change channels. We asked a member of staff why the remote control was not kept in the lounge and they told us they did not know. People were unable to access and use the kitchen when they wanted and or to get food and drink without first seeking permission from staff. We noted a sign in the kitchen stating, 'residents who wish to have a snack before 10pm may do so under supervision'.
● Due to the concerns we found we raised four safeguarding referrals to the local authority following our inspection.
● Policies and procedures in place for safeguarding adults and children were not up to date or robust. The provider's safeguarding policies and procedures had not been reviewed or amended to reflect current best practice. For example, the policy referred to CQC 'compliance' which was replaced in 2015. The policy did not record all forms of abuse that changed with the introduction of the Care Act 2014. The provider had safeguarding policies and procedures for all funding local authorities, however again these were years out of date and had not been reviewed to inform staff of correct best practice. We saw there were no safeguarding referrals or records retained at the service and no analysis or monitoring tool in place to manage, monitor and learn from safeguarding concerns. We drew these concerns to the registered manager attention.

The provider had continued to fail to ensure that people were protected from instances of potential abuse. This was a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At our last inspection risks to people were not always assessed and managed to ensure their health and safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks to people's health, well-being and safety continued to be inadequately identified, assessed and reviewed to ensure people's safety and well-being. Risks associated with people's needs were not always identified and managed safely by staff to avoid possible harm. For example, where there were known risks and or risk behaviours these had not been identified or assessed to support, manage and mitigate the risks.
● One person's pressure area risk assessment (waterlow) recorded they were at high risk of pressure wounds; however, the record was last completed by staff on the 7 May 2019. The person's care plan recorded that they had a grade 2 pressure area, however the registered manager told us that no one using the service had pressure wounds and did not know of the risk to the person. This left people at risk of not receiving the appropriate care and support to meet their change in needs.
● Another person required the use of a specially suited wheelchair and a celling track hoist to transfer and mobilise safely, however there was no risk assessment in place or guidance for staff on the safe use of the equipment. The person's eating and drinking risk plan did not detail the seating position required whilst eating to ensure the risk of choking and acid reflux was minimised. We drew these concerns to the registered managers attention who following our inspection sent a revised version of their risk plan. Despite some apparent risks identified with the persons eating and drinking needs we noted that the provider had failed to refer the person to health care specialists such as the speech and language team (SALT) for support and guidance. We discussed this with the registered manager who told us they would refer the person to the

SALT following our inspection.
● Although an environmental and fire risk assessment were in place arrangements to deal with foreseeable emergencies and to maintain the safety of the premises were not robust or routinely completed in line with regulations and best practice. For example, a fire risk assessment was completed on 30 July 2019 and stated emergency escape lighting tests were to be completed. We asked the registered manager to show us records of the emergency lighting tests being completed as required in the fire risk assessment. They told us they were completed but staff were not recording them.
● Fire drills were conducted, however records of them did not list the staff involved. This meant the provider could not be sure all staff understood what to do in the event of a fire to reduce risks to people. Water temperature checks were not completed to reduce the likelihood of scalding.

The provider had continued to fail to ensure that risks were appropriately assessed and action was taken to mitigate them when possible. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
At our last inspection the service did not always learn from accidents or incidents and when things go wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Although the provider had recorded accidents and incidents that had occurred, records were inconsistent and there was no analysis or monitoring tools in place to manage, monitor or learn from accidents and incidents.
● Where accidents and incidents had occurred, we saw these had not always resulted in reviews or reassessments of people's needs and risks being completed and changes to people's care plans were not always undertaken as a result to minimise risk of further harm.
● Records showed that where staff had identified accidents and incidents appropriate actions were not always taken to address them and referrals to local authorities and health and social care professionals was not always made.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were managed, administered and stored safely.
● There were policies and procedures in place to ensure people received their medicines as prescribed by health care professionals. Protocols were also in place for people's individual medicines including 'as required' medicines. Medicines administration records were completed appropriately by staff and checks were conducted to ensure continued safe administration.
● Staff received medicines training and had their competency to administer medicines safely assessed.

Staffing and recruitment
● There were enough staff to meet people's needs and recruitment systems were in place to reduce identified risks.
● One person commented, "There are staff around if we need them. They take me out sometimes."

● Staff were recruited safely. Employment checks were completed before staff started working with people. These included gaining accurate references and a full employment history. Disclosure and barring service (DBS) checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Preventing and controlling infection

● People were protected from the risks of infection and the home environment appeared clean and well maintained.

● Staff received training on infection control and food safety. Staff were provided with personal protective equipment such as aprons and gloves.

● Staff supported people to understand how to reduce the risk of infection and helped them to maintain good personal and environmental hygiene.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Requires Improvement'. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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.

● The provider failed to seek and assess capacity where appropriate and work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Where restrictions on people's liberty had been authorised, conditions on their DoLS authorisations were not being met.
● A condition on one person's DoLS, stated, 'The Managing Authority to inform the supervisory body if the appointed Relevant Person's Representative (RPR) ceases to visit at least every 6-8 week.' We asked the registered manager how often the persons RPR visited and initially they told us every three to four months. We asked if they had informed the DoLS office that this was not meeting the conditions and they told us no.
●There were no systems in place to monitor how regularly the RPR visited. We noted the visitor's book recorded that they visited on several occasions, however between 1 February 2019 and 10 June 2019, a period of over 15 weeks, there was no evidence that the RPR had visited.

The provider had failed to ensure that conditions on people's DoLS were met. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's legal rights were not protected because mental capacity assessments and best interest decisions were not always completed and staff did not follow or act in accordance with the MCA and DoLS.
● For one person we saw that the provider had failed to seek and assess their capacity and work within the principles of the MCA in relation to their consent to seclusion. This was a practice that was consistently

carried out within the service. For another person we saw that an MCA had been completed for the decision on where they chose to live. However, the MCA had been incorrectly completed. For a third person we saw that no MCA's had been completed in relation to any areas of their care and treatment within the service despite the person having a DoLS authorisation in place.
● The registered manager and staff lacked understanding and the application of the MCA and DoLS and its principles despite training records confirming training had been completed. The lack of knowledge had impacted on people's rights.

The failure to work within the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards meant that people's rights were not upheld or protected. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were unable to consent to living at the service and we saw the registered manager had applied for DoLS when necessary. Some of these had been authorised by the local authority. However, the registered manager had failed to notify the CQC that authorisations were in place as required by law.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they moved into the home. One person told us, "I visited the home first to see if I liked it. Staff talk to me about my needs." However, records showed that people's needs were not always reassessed or reviewed in a timely manner when changes in people's needs occurred and this required improvement.
● Assessments were used to help produce care plans and some nationally recognised assessment tools, such as the Waterlow assessment tool to assess people's skin integrity were in place. However as previously identified these tools were not consistently completed or followed by staff.
● The service also followed the Care Programme Approach (CPA) to assess and support people with their mental health needs. The CPA is the programme of support offered to people who need support with their mental health.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to meet their nutrition and hydration needs. However, people were not always supported to maintain a balanced diet and or offered choice of foods and this required improvement .
● People told us they enjoyed some of the foods on offer, however they were not always given a choice. One person said, "The food is ok but sometimes I don't always like the way it's cooked. The ingredients are not always to my liking, I don't like the potatoes they use. We don't get much choice and if we don't like what is on offer in the evenings we are offered a microwave meal." Another person commented, "We always have sandwiches for lunch which are ok but it would be nice to have a choice or something different like jacket potatoes."
● People had told the provider about the food on offer at the home and the changes in menus they would like. People had stated they would like an alternative to sandwiches at lunchtimes. Minutes of resident's meetings documented this and menus in place confirmed that sandwiches were always served at lunch times. We drew this to the registered managers attention who told us this would be discussed with people before any changes were made.
● Although care plans documented people's nutritional needs and any support they required with meal preparation or at meal times, they did not always record people's cultural preferences and any nutritional risks such as swallowing difficulties or choking. For example, one person's eating and drinking risk plan did not record the position the person should be supported to adopt at meal times to minimise the risk of

choking and to help avoid reflux. We drew this to the registered managers attention who on the second day of the inspection reviewed the persons eating and drinking risk plan to include the safe correct seating position.
● The Food Standards Agency visited the service on 06 February 2018 rating them five which is the highest rating a service can achieve.

Staff support: induction, training, skills and experience
● Staff knew the people they supported, however they did not always have or display the skills and knowledge to meet people's needs appropriately in line with best practice.
● Staff received training in a range of areas such as, safeguarding, MCA and DoLS, medication management, moving and handling, first aid, managing challenging behaviour, person centred planning and understanding mental health.
● There were processes in place to ensure staff new to the home were inducted into the service appropriately. Staff completed an induction programme in line with the Care Certificate, a nationally recognised programme for health and social care workers.
● Staff received supervision, support and an appraisal of their practice.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People's physical, mental and emotional needs were assessed and documented in their plan of care. Staff monitored people's daily well-being to ensure they were supported appropriately.
● Staff worked with health and social care professionals to plan and monitor people's well-being.
● Staff supported people when required and accompany them to appointments. Records of health care appointments were retained in people's care plans documenting any treatment required or received.

Adapting service, design, decoration to meet people's needs
● The service was adapted in certain areas to meet people's needs and the garden and outside space was accessible to some people.
● People were encouraged and supported to decorate their own rooms with items specific to their individual taste and interests.
● People had access to specialist equipment that met their physical needs. For example, walking frames, wheelchairs and hoists.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Requires Improvement'. This meant people did not always feel well supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity

- Aspects of staff practice was not always caring. People gave mixed feedback about the kindness and supportiveness of staff. Feedback from one person's relative in a questionnaire stated, 'Staff are friendly.' However, one person said, "Some staff are nice and they help you but others are not." Another person commented, "Its ok but some staff are not very kind or friendly. You can't always do what you want to do." A relative told us they felt staff were not always caring and the culture within the home was quite restrictive and did not promote people's independence. They said, "I feel [relative] and others are treated as though they are in a hospital environment rather than them being in their own home.
- We observed that staff did not always interact or communicate with people kindly or effectively when supporting them or when in the same room with them. We observed the registered manager speaking to one person in a stern and derogatory manner when requesting they complete their personal care.
- In line with RRS principles we discussed person centred active support (a model of care which promotes independence for people with learning disabilities) with the registered manager and in relation to one person. They told us, "[Resident] can't do that. [Resident] is impaired." This required improvement. We saw that other staff had built positive respectful relationships with people.
- People's diverse needs were assessed and documented as part of their plan of care. Care plans included information about people's cultural requirements and spiritual beliefs and how staff supported them to meet their needs. For example, one person visited their family on a regular basis and attended their place of worship.
- Staff received training on equality and diversity and worked to ensure people were not discriminated against any protected characteristics they had in line with the Equality Act 2010.

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

- People were not always supported to make their own decisions or to be involved in planning and reviewing their care.
- Some people were unable to communicate their views and wishes verbally. The registered manager told us that most people's preferred communication methods were verbal apart from one person. However, people told us and we saw that they were not always involved in developing and reviewing their care plans. One person said, "I don't always get told what's going on or why things happen." Care plans were not accessible to people or developed in a way that was meaningful to them, such as using pictures or easy to understand formats.
- People were not provided with information about the service in the form of a service user guide in a format that met their needs, for example, easy to read or pictorial versions. This meant people were not supported

to be involved in planning and discussing their care and were not also given options and choices.

Respecting and promoting people's privacy, dignity and independence

● People's privacy, dignity and independence was not always respected or supported. One person told us, "I would love to be able to have the support to buy my own healthy foods and cook them but I'm not allowed." Another person commented, "I would like to be able to cook but staff do that."

● The service did not apply the principals and values of 'Registering the Right Support' and other best practice guidance. These ensure that people who use the service can lead a full a life as possible and achieve the best possible outcomes that include control, choice and independence. There were no care plans in place to support and promote people's independence and to develop their skills. For example, there were no care plans to support one person to have more control over their finances or to support them with daily activities such as cooking.

The provider failed to ensure that care was planned and delivered in a person-centred way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as 'Requires Improvement'. At this inspection this key question has remained the same. This meant people's needs continued not to be met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.
At our last inspection of the service on 23 October 2018 we found people's needs in relation to their cultural, religious, and sexuality were not identified and planned for and this required improvement.

At this inspection we found some improvements had been made.

- Some improvement had been made in relation to identifying and assessing people's diverse needs. However, care plans were not always up to date and some contained information which did not reflect people's current needs. For example, one person's care records recorded that they liked to smoke, however we were later told that the person had not smoked for over a year.
- Reviews of people's care needs and records were not always conducted when a change in need occurred or when required.
- Daily records kept by staff showed inconsistent monitoring and recording of people's health needs and well-being. For example, one care plan recorded that the person had a graded pressure area, however there were no body maps in place to track progress with healing or any deterioration and the care plan was last reviewed in April 2019 so may not reflect their current needs.

The provider failed to ensure people received personalised care and to maintain an accurate, complete and contemporaneous record for each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager and staff lacked knowledge and understanding of the AIS. The provider had failed to produce information and documents in a format that met people's needs such as easy to read assessments, care plans, service user guides and the complaints procedure.
- The registered manager and staff did not promote, enhance or support communication. For example, one person using the service had profound disabilities limiting their verbal communication. There was no provision made or available to use communication aids or methods to enhance communication with the person. We also saw that no referral had been made to the SALT team for guidance and information about effective communication with the person.

The provider failed to ensure that care was planned and delivered in a person-centred way. This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There was not an effective system in place to effectively identify, receive, record, manage, respond and monitor complaints.

● People told us they had raised issues and complaints to the provider, however these were not always managed and responded appropriately to the complainant's satisfaction. One person said, "I tell them [staff] when I'm not happy with something but they don't always listen or do anything."

● The provider failed to produce their complaints procedure in different formats to meet people's needs, such as an easy to read version.

● We asked the registered manager if they had received any complaints since our last inspection of the service. The registered manager told us no complaints had been received. However, when reviewing records, we identified that a relative had made a complaint. We saw that the registered manager had met with the relative to discuss their concerns. However, there were no systems in place to identify, receive, record, manage, respond and monitor to learn from complaints.

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

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported by staff to access leisure activities to meet their needs and interests. For example, one person was supported to attend a local hydro pool and another person was supported to visit a sensory service. One person told us, "I went out yesterday to sing in a choir, I enjoyed it very much."

● We observed that staff supported people to pursue their interests inside and outside of the home environment. During our inspection we saw one member of staff playing cards with one person.

● Although people were supported to take part in activities, people were not always supported to achieve personal goals and or to enhance their independence. For example, there were no plans in place to show how people's personal goals were to be achieved in areas such as cooking and doing their laundry. One person told us, "I'm not allowed to cook without permission and they [staff] only allow me to do one load of washing a week." This required improvement.

End of life care and support

● The registered manager told us that no one using the service required end of life care and support at the time of our inspection. However, they said they would liaise with health and social care professionals and specialised services including local hospices to provide people with appropriate care and support if required.

● People were supported to make decisions about their preferences for end of life care if they so choose and these were retained in their care plan for reference.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as 'Requires Improvement'. At this inspection this key question has now deteriorated to 'Inadequate'. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care
At our last inspection the management of the service needed improvement as there were a number of failings in the service that had not been identified through quality monitoring systems. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider and registered manager did not recognise the importance of regularly monitoring the quality of the service to help ensure safe good service delivery and to help drive improvements.
- There were failures in identifying and addressing areas of care which required improvement, ensuring people received safe care and treatment. There continued to be significant shortfalls as quality assurance systems failed to identify the concerns and issues we found at the inspection and as detailed in this report.
- These included, the failure to identify, report and respond to concerns appropriately and in line with safeguarding policies and procedures and the failure to assess, review and monitor people's safety and well-being. The failure to identify the use of restraint, seclusion and segregation practices within the service which were unlawful and not in line with best practice. The failure to seek and assess capacity where appropriate and work within the principles of the MCA and DoLS. The failure to ensure policies and procedures were robust and up to date with current legislation and best practice.
- Accidents and incidents were inconsistently managed. There was no analysis or monitoring tools in place to manage, monitor or learn from accidents and incidents, and a failure to notify the CQC that DoLS authorisations were in place as required by law. The provider and registered manager failed to establish and operate a system for identifying, receiving, recording, handling and responding to complaints. There was a failure to ensure and monitor that people received personalised care and to maintain accurate, complete and contemporaneous records.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
- There were systems in place to seek the views of people through reviews, keyworker meetings, resident's meetings and surveys. However, feedback from people which was recorded in the resident's minutes, identified and requested changes to the service. We saw that these were not always responded to or acted on and this required improvement.

The provider failed to ensure safe management oversight, to seek and act on feedback, assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager did not fully understand their responsibility under the duty of candour and were not always open and honest during the inspection. For example, not being aware and knowledgeable of changes in legislation and practice and changing details and information provided to us throughout the inspection. They failed to take responsibility when things went wrong and did not keep their knowledge and understanding regarding best practice, or changes in fundamental standards and regulations up to date.

● The registered manager had led the service for many years. They were aware of their registration requirements with CQC and were aware of the legal requirement to display their CQC rating. However, they continued to fail to notify the CQC of all incidents that affect the health, safety and welfare of people who use the service.

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

● People and their relatives gave mixed feedback about the care and support provided and the management of the service. One person said, "[Staff member] is very good and cares, they are the best here. The manager is not always good to speak with." Another person commented, "You have to fit in with them [staff], you can't always do what you want and some staff are not always very nice." A relative told us, "I would be worried about [relative] if I didn't visit often."

● There had been a lack of improvements made since our last inspection of the service which was due in part to a lack of good management, leadership and oversight. This meant people did not always achieve good outcomes and staff did not benefit from an open, empowering and positive culture.

Working in partnership with others

● The service worked in partnership with commissioners from the local authority and with health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that care was planned and delivered in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, well-being and safety continued to be inadequately identified, assessed and reviewed to ensure people's safety and well-being. The provider did not always learn from accidents or incidents and when things go wrong.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to work within the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This meant that people's rights were not upheld or protected.

The enforcement action we took:

We issued a Warning Notice in relation to Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from avoidable harm. The provider continued to fail to report and respond appropriately and in line with safeguarding policies and procedures. The provider failed to seek and assess capacity where appropriate and work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Where restrictions on people's liberty had been authorised, conditions on their DoLS authorisations were not being met.

The enforcement action we took:

We issued a Warning Notice in relation to Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure people received personalised care and to maintain an accurate, complete and contemporaneous record for each person. The provider failed to identify and address areas of care which required improvement,

ensuring people received safe care and treatment. There continued to be significant shortfalls as quality assurance systems failed to identify the concerns and issues we found at the inspection.

The enforcement action we took:

We issued a Warning Notice in relation to Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.