Annette's Care Limited

Annette's Care Limited

Inspection report

96 Albert Road
Plymouth
Devon
PL2 1AF

Tel: 01752560300

Date of inspection visit:
20 March 2019

Date of publication:
29 April 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Annette's Care is a residential care home that was providing accommodation and is registered to provide personal care for up to 4 people with a primary need of Learning Disability. However, at the time of the inspection the care home was also supporting people whose primary need were mental health issues. Some people also had additional learning difficulties and physical disabilities. The care home is located on one site with four individual bedrooms. On the day of the inspection there were three people living at the service and one person on respite.

People's experience of using this service:

- People who had lived in the service for many years mainly said they were happy.
- Risks in relation to people's care and lifestyle were not assessed, understood and managed in a way that kept them safe. Some practices in relation to risk did not protect people's human rights.
- People did not live in an environment that was well-maintained or promoted their dignity.
- People's rights in relation to their capacity had not been fully understood and respected. Correct processes had not been followed when people lacked capacity to make decisions about their care.
- Risks and needs in relation to people's physical and mental health had not been consistently understood and supported.
- The culture of the service did not respect and promote people's rights, dignity and independence.
- The organisation of the service was poor. Leadership and auditing of the service had not been robust and had failed to identify the concerns we found in relation to practice, the environment and the culture of the service. This meant that people had continued to receive a service that was not safe, effective, caring or responsive to their needs.

- The service is now judged to be inadequate in keeping people safe, providing effective care, being caring, responsive and being well-led.

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

Rating at last inspection: The rating at the last inspection was Good (the last report was published July 2017)

Why we inspected: We inspected in line with our inspection methodology. The inspection was prompted due to concerns received from professionals.

Enforcement

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.

Follow up:
Following the inspection we spoke to Plymouth City Council about our initial findings and practices we had concerns about. We also contacted Devon and Somerset Fire Service to share our concerns related to fire safety.
The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Annette's Care Limited

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:
The inspection was completed by two inspectors from the adult social care inspection team.

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

Annette's Care is located in a city location.

The care service was not aware and had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion.

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 when preparing for and carrying out this inspection:

Prior to the inspection we reviewed information we held about the service, such as feedback we had received from health and social care professionals and provider notifications. A notification is information

about important events such as incidents, which the provider is required by law to send us. We reviewed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection, we spoke with four people who used the service. Some people living at Annette's Care had limited verbal communication, and it was therefore limited in what they could tell us about their care and the service they received. We observed the care in the communal areas.

We spoke with the deputy manager and three members of staff. We reviewed a range of records. This included four people's care records such as support plans, medicines records and accident and incident reports. We also looked at three staff files. We looked at recruitment records, supervision notes and training information shown to us. A range of records were also reviewed relating to the running of the service including, policies and procedures and audits.

Prior to the inspection we contacted a mental health nurse.

Following the inspection, we spoke to the local authority team and two professionals.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

•People's records did not always reflect their current risk and were not being updated when something changed for them, which left staff with inaccurate information. For example, if people's mobility or health had changed.
•People with known risks associated with their mental health and behaviours did not have these clearly assessed. We were told about people who could at times display behaviours that could put them or others at risk. These risks were not detailed as part of a risk assessment or plan of care for the people concerned. This meant that staff may not be supporting people consistently or in a way that safeguarded and protected them or others.
•People who had known risks associated with health conditions did not always have their needs identified, assessed and acted on to keep them safe. For example, one person had a known history of epilepsy. Although they had not had any recent seizures, there was not a robust care plan in place in the event they did.
•Several people had continence needs, risk assessments in relation to their needs were not robust. For example, one person was susceptible to urine infections. There was no guidance in place to say how these risks should be mitigated and the person supported to reduce the likelihood of infections.
•We were concerned we saw people eating food which did not reflect the advice given by the speech and language team. For example, one person had been advised to have food in "bite sized chunks", they had a sandwich in quarters. There were no choking risk assessments in place.
•The deputy manager and staff told us some people had known risks associated with managing their own finances. There were no risk assessments in place regarding people's finances, therefore it was not possible to see if risks associated with people's money remained relevant, as there was no description of what these needs were, or of the support people required.
•The management of people's money was not safe. For example, there was not a clear audit trail regarding people's expenditure.
•One person had a van. We were told they have given their permission for it to be used by other people at the service. We saw people had substantially financially contributed to petrol. However, there was a lack of record keeping relating to the vehicles use, mileage and associated costs, which meant we were unable to check the vehicle was used appropriately.
•Where staff were using their own vehicle to transport people we were unable to see any evidence the provider had checked vehicles were road worthy and staff vehicles were insured for business purposes.
•We had several concerns about fire safety during the inspection. We found significantly faulty electrical wiring in one person's room, a fire door with no handle and the front fire exit door was locked with staff holding the key. We were concerned one person was smoking in their room. We immediately asked the manager to unplug the electrical wires and keep the key by the front exit door. Following the inspection, we

asked the Devon and Somerset Fire Service to inspect the service and we received an email from the manager telling us a key safe had been purchased and the fire door had been fixed.
•One lounge area of the service had an open tool and drill box on the floor. Sharp tools including a knife and nails were accessible to people. We asked staff to move these to a safe area. Later in the same week on two separate occasions, visiting professionals advised the open tool boxes and unsafe equipment were once again unattended in the communal areas of the service. The deputy manager told us these tool boxes would be kept in a new shed in future.
•Cupboards with electrics were unlocked which might pose a risk to people.
•The water temperature in the upstairs communal bathroom was over 100 degrees when we tested it. This could have scalded people. Following the inspection the deputy manager told us a new valve had been fitted.

Learning lessons when things go wrong

•The provider had systems in place to record incidents and accidents. However, we saw no evidence of a system to analyse this information or to recognise and respond to patterns and triggers.
•Incident forms did not describe the action taken by the deputy manager or the provider to address incidents or errors or to check if the action taken by staff at the time of the incident had been appropriate and safe.
•Staff communication and recording of people's daily care was not robust enough to ensure changes in people's care, mood, and risks were passed on, reviewed and monitored.

Using medicines safely

•The provider's medicine audit identified medicine management as safe and did not identify the concerns we found.
•The service typed and printed out their own medication administration records. These did not always correspond with people's prescription, which meant,for example, the dose of medicine prescribed on occasions differed from what was directed on the medicine sheet.
•We found a person's medicine sheet did not correspond with a doctor's note we found or the instructions on the medicine. This meant we were unable to tell whether they had received the correct amount of medicine. We asked staff to follow this up.
•The printed-out medicine record caused errors because the timings of medicine were not in the correct place, for example people's evening medicine was in the column usually used for morning medicines.
•There was no safe system in place regarding medicine keys. During the inspection the medicine keys were held with several different members of staff. This meant several staff were accessing the medicine cupboard and there was no record of who had access at any time.
•People did not have medicine care plans detailing the medicine they took and any possible risks or side effects. Some people were on medicines that required regular blood tests and carried potential risks. Whether these checks and tests had taken place was not known nor was recorded.
•People did not have clear protocols in place regarding the use of occasional medicine for example, paracetamol.
•We found one person's 'as required' medicine was out of stock. When they needed this during the inspection and were in pain, they had to wait until staff collected some from the pharmacy.
•Dates of cream, bottles and nasal sprays had no date of opening on them.
•Some people had skin creams in their rooms but there were no risk assessments in place to assess whether people were safe with these medicines in their room.
•There were no body maps in place to guide staff where skin creams should be applied.
•There were occasional missing signatures on the medicine charts but when we checked the stock of tablets,

the amounts indicated people had received their medicines. We were unable to check the liquid medicine stock as there was no date of opening on the bottle.
•Although staff had completed online medicine training and had their competency checked, they were not following basic medicine administration safety checks.
•The day after the inspection, the deputy manager told us they had sought advice from the pharmacist and were working with them to improve the current medicine management system.

Preventing and controlling infection

•Although, policies, procedures, training and checks were in place in relation to infection control, parts of the environment were not clean and hygienic.
•Some areas of the service smelled strongly of urine.
•People's dirty linen baskets were in the lounge area. Toilets and bathrooms we visited had empty bottles of hand wash. There were no foot operated pedal bins which would help prevent cross infection. One bathroom had a used towel in it which germs could spread from and put people at risk. Some staff told us that they have received infection control training and the other staff we spoke with told us they will be doing it soon.
•Staff undertook the cleaning at the service but checklists to evidence this were incomplete.
•We saw personal protective equipment around the service, however only saw one staff member with an apron on whilst in the kitchen area.

The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment

•Robust recruitment processes were not followed. These help ensure staff employed are safe and suitable to work in the service. Records were missing completed applications, full reference checks and disclosure and barring checks (DBS) relating to the service where staff were working.
•Where substantial risks were known, for example convictions which had been identified during staff recruitment, there were not robust risk assessments in place to safeguard people and there was a lack of ongoing monitoring in place. The deputy manager told us new DBS checks had been applied for but this evidence was not apparent during the inspection.

The above concerns demonstrated a failure to operate safe recruitment practices which was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

•Most days the staffing rota showed that three staff were on duty to support people between 8am to 8pm. Two people required hoisting and therefore two staff to carry this action out safely. Another person required two staff to move them safely due to their mobility needs and the fourth person was only able to leave the property with the support of two staff. The three other people also all needed staff support to go out. People were rarely going out of the care home. There was no system in place to assess safe staffing levels required for people's needs and promote social inclusion. Staffing at the home was not always adequate to keep people safe or to enable people to have a fulfilled and active life outside the home.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

•The Commission had not been notified by the service of any incidents of a safeguarding nature prior to the inspection.

•All staff undertook training in safeguarding vulnerable people.

•People's care plans lacked guidance about how staff would protect them from the risk of abuse for example, those vulnerable to discrimination, harassment and exploitation in the community.

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

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

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

•The environment was tired. The home was scruffy, walls were scuffed and stained with food debris, paint was peeling and where holes in the wall had been filled, they had been left unpainted and not fully repaired. One communal area was furnished, the other which we were told had previously been a sensory room, was now used for night staff resting. The television was the focal point in the main lounge for visual stimulation and activity.
•Some people's bedrooms in poor condition with furniture damaged and broken. Another person had two divan beds and a spare mattress stored in their bedroom and there was no room lightbulb. Flooring was damaged around the service and some people had holes in their bedroom flooring. One bedroom had frayed electrical wiring hooked through their window and around their room to an overloaded plug. There was pipework which was unboxed which had the potential to be a ligature point. Outside another person's bedroom was a space filled with bags and items which required storage and was potentially a fire hazard. Carpets were worn and frayed up the stairs which could represent a trip hazard.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•During the inspection the manager made the frayed electrical wiring safer. We requested they arrange a new bed for one person. Following the inspection, the manager contacted us and said the whole building was going to be painted in April.

Ensuring consent to care and treatment in line with law and guidance

•We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

The Mental Capacity Act provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes and hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards. (DoLS).

•People had decisions made about their care, which had not been evidenced as having been done so in their best interest. There was no evidence of people's involvement in decisions which had been made. For example, having their money managed in a certain way. We were told some people had capacity, however, their money was held and managed by staff. It was not evident how or why decisions about people's money had been made.
•We were told people had capacity or lacked capacity. However, records did not demonstrate people's ability to make decisions had been assessed, or how staff recognised that capacity might fluctuate or change dependent on the activity or changes in situation or health. We found generic capacity assessments in place for multiple areas of care. There was little evidence of people, or those who knew them well, being involved in discussions. For example, family, advocates or professionals.
•Some people had periods of time when they had supervision from staff for example one to one care. We were also told some people needed staff support at all times when they went out. Only one DoLS assessment was in progress to reflect this level of support. This could mean people were deprived of their liberty without the appropriate authorisations in place. There was no recorded evidence of any other DoLS applications being in progress.
•Some people at the service had previously been under the Mental Health Act (MHA) and been subject to supervised community treatment. There was little individualised evidence regarding how the provider supported people to maintain the MHA conditions in place.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

•Most people had lived at the service for many years. Admission records were poor and not fully reflective of people's care needs. One new admission had little paperwork and staff knew very little about the person's background.
•We were told initial assessments were completed and used to develop a care plan for the service. These lacked details of peoples' backgrounds, life history and associated health needs and risks.
•We found risks associated with people's care that demonstrated the service was not always ensuring people's needs were met, for example we received concerns from professionals that appointments for medical care were being missed.
•Care records lacked information about how the service would support people to meet their physical health needs, emotional needs and any behavioural needs.
•We found concerns throughout the inspection that reflected care was not always being given in line with standards, guidance and regulations. For example supporting people with personal hygiene needs, social inclusion opportunities and the management of medicines.
•Handover of people's information was poor. We asked a staff member about a person who had been recently admitted to the service. They did not know the person's surname or care needs. They told us they had been off for a while but they were in charge when we arrived.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care.

•Staff told us support had been requested from other agencies in relation to people's needs or when people's health had changed. For example, one person was unwell during the inspection. We were told by staff the doctor had been called to attend. However, there was little recorded evidence of referrals and / or of discussions held.
•Following the inspection, we received information that the doctor had advised the person was taken to the surgery. This did not occur as requested by the medical team supporting the person.
•We saw some people had been referred to the Speech and Language service due to swallowing difficulties. However, during the inspection we saw the advice given regarding one person's diet was not being followed, this could have put the person at an increased risk of choking.
•Some people had learning disability needs, other people, mental health needs. There was minimal recorded evidence of involvement or advice sought from the local learning disability service or the mental health teams to support people's recovery and rehabilitation. Following the inspection, the deputy manager told us they did ask for support but did not feel supported by mental health services.

Supporting people to live healthier lives, access healthcare services and support

•One of the concerns we received prior to the inspection visit was that people had missed important hospital appointments. The lack of good record keeping meant we were unable to evidence whether people had attended specialist appointments or not. We had also received concerns prior to the visit that mental health professionals had not been able to visit someone they were required by to see by law because staff would not let them in.
•Care plans did not describe the support needed to maintain people's health and well-being.
•People's care records were disorganised and did not provide clear detail to staff and others about their past and current health needs. Information about people's health was found to be randomly filed amongst other records, including other people's records.
•People did not have health action plans, communication passports or hospital passports where required. Hospital Passports include information about people's needs and how they choose to be supported. This information helps ensure people receive consistent care in the way they need and prefer, if they are admitted to hospital or other healthcare facility. Following the inspection, the deputy manager advised us these were now in place.
•There was no written evidence that people had received flu jabs or smoking cessation advice if they had wanted this. There was no evidence exercise or healthy eating advice had been offered.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

•There was a communal kitchen for people's use.
•People's likes and dislikes relating to their food preferences was recorded.
•The food we saw in the fridge was opened, undated and unlabelled. The fridge contents included pork pies, ham and sausage rolls and juice. The fruit bowl in the lounge had some fruit, some of which was mouldy.
•However, staff told us they knew who was at nutritional risk and they were encouraging food and fluid. We also saw staff offer to support someone struggling to peel a satsuma.
•We saw that some people had been given beakers where they were at risk of hot drinks spilling and scalding them.

•The service operated a weekly menu with a "take away, special treat" on a Saturday provided by the service. One person told us "the food is great".
•The service achieved a four star food hygiene rating in 2013 from the Environmental Health service.

Staff support: induction, training, skills and experience

•There was no evidence of a robust induction for staff new to the service.
•Although the deputy manager was familiar with the Care Certificate, there was no evidence new staff had undertaken this where required.
•There was a range of essential training in place which staff were working on completing and we were told staff held health and social care qualifications.
•The deputy manager told us that a training matrix had been set up but when we asked to see it, they were unable to find it on the computer during the inspection.
•Staff had a good verbal understanding of safeguarding and consent.
•Not all staff had completed training on health conditions relevant to the people they were caring for, for example mental health training, autism, incontinence and skin care. Where training had occurred, there was no management oversight staff had understood the training and benefitted from it.
•The deputy manager told us the day after the inspection they were encouraging staff to complete these courses.
•The staff told us they felt well supported by the deputy manager who provided recorded supervision and appraisal for them and informal support.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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

Inadequate: People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Respecting and promoting people's privacy, dignity and independence

•Practices did not always promote independence and empower people, and people's cultural and spiritual needs were not always recorded and / or promoted.
•Support plans were mainly on people's personal care needs rather than on the whole person, their lifestyle and progress. For example, staff completed a tick box daily checklist to evidence the care provided rather than individualised daily care records.
•Support plans did not describe the support needed by people to maintain their bedrooms, hobbies or any plans in place to help them to develop and progress their independent living skills for example cooking and budgeting.
•We saw people's private, confidential information about their health on noticeboards and found people's records in other people's care files.
•Other agencies expressed concern about the culture of the service, staff professionalism and staff knowledge of mental health.
•We saw one person with very long, unclean nails. The person asked staff to cut these. Staff said they did not cut nails. There was no evidence this person's fingernails were cared for regularly.
•People had low expectations of care and people's views were mixed, "The staff are very good people" and, "It gets very hard for me and I get very lonely." Mostly, people told us they liked living at Annette's Care.

Ensuring people are well treated and supported; respecting equality and diversity

•Staff welcomed people into the home regardless of their differences. However, information provided to people when they first moved into the home did not tell people that their differences and diverse needs would be understood, respected and welcomed.
•There was no evidence of people's cultural, sexual or spiritual needs being noted on their admission information or in their support plans.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

•Staff told us they cared for people like their own family.

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

•People's support plans did not evidence how people were involved in matters concerning the home, their health, their social needs or their finances. Staff had signed to say support plans had been reviewed but it was not evident if and how people had been involved in this process. Support plans were not in date, but many were in an easy read format people could access and understand if they had seen them.
•There was a leaflet on advocacy but no evidence advocates had been involved with people at the service.
•There was no evidence of house meetings to involve people in events happening at the service.
•We saw that people were meant to have a monthly meeting with the manager and following the inspection we were sent evidence of some meetings held with one person. However, we were unable to see evidence that things people had said they would like to do each week, for example bingo were followed through by the service.
•One person told us they had chosen the colour in their room.
•Another person's support plan included the things they enjoyed, doing for example going to Mc Donald's.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service responsive?

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•People's support plans did not detail what people did each day. People's aspirations and wishes had been documented but there were no plans around how staff were going to support people to achieve these. For example, it was noted people had said they would like a passport or to go to college. These had not happened for people and it was not clearly recorded what action the service had taken to support people to meet their goals. Following the inspection, the deputy manager told us they had helped people save for their own vehicle.
•Support plans were not reflective of people's current needs, strengths nor demonstrated recovery orientated care planning. Support plans did not reflect how the service was promoting people's well-being, emotional health or quality of life. However, we did see some support plans with personalised information, though these required updating to reflect people's current situation.
•There was little evidence of value being placed on people's social opportunities. For example, activities were minimal for people and inconsistent. The noticeboard was out of date with the last activities on offer being 17 February 2019. The March 2019 activity plan was blank. Following the inspection, the deputy manager sent examples of new activity sheets and confirmed people did go out but they sometimes declined.
•We had received concerns people were not going out. No one went out during the inspection. One person watched television in the lounge or slept, another played on their gaming station. Two other people had minimal social interaction or stimulation all day.
•Some people had difficulty with verbal communication. We looked at how the provider complied with the Accessible Information Standard (AIS). This is a legal requirement to ensure people with a disability or sensory loss can access and understand information they are given. Although some staff knew people well, information and aids to support people's communication needs were very limited. Support plans did not reflect how best to communicate with people.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following the inspection, the deputy manager sent us minutes of meetings held with one person discussing social opportunities. The lack of good record keeping at the time of the inspection meant we were unable to evidence if people did attend activities on a regular basis. Information received from the deputy manager following the inspection told us these areas had been improved.

Improving care quality in response to complaints or concerns

•The provider had a written complaints procedure, and complaints received had been responded to. We reviewed some of the responses and found although action had been taken to improve things in the short term, these improvements were not sustained due to a lack of management oversight and monitoring of staff. The complaints procedure was not visible in the home and we did not see it available in a format accessible to people who used the service.

End of life care and support

•At the time of the inspection the service was not supporting anyone with end of life care.
•Support plans did not include any information about people's end of life wishes.

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

Inadequate: 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•The provider / registered manager did not have a formal set of values.
•The service was not being effectively assessed and monitored by the provider to ensure its on-going safety and quality. The provider had failed to recognise that people lived in an environment which did not always have a positive and inclusive culture and was unsafe.
•The providers ethos was not promoting people's independence and this was not embedded into staff practice. People were not being supported to be empowered and motivated to live fulfilled lives.
•The inspection was supported by the deputy manager. The registered manager who was also the provider did not attend. We sent feedback following the inspection to both.
•The service did not demonstrate an awareness and understanding of 'Registering the Right Support'. Registering the Right Support is guidance relating to services supporting people with learning difficulties and the underpinning principles of choice, promotion of independence and inclusion. For example, care plans did not consider people's long-term needs, development of skills, and their independence were not being adequately considered.
•Although there were a range of audits and checks in place, these had not identified the concerns we found related to the safety of the environment, medicines or recruitment failings.
•Following the inspection feedback, the deputy manager told us they had contacted the pharmacist for support and were putting a plan in place to address the environmental concerns.
•The service was admitting people with conditions they were not registered with the Commission to support, for example people with mental health needs.

Continuous learning and improving care

•The provider did not have sufficient oversight of the service to ensure regulations were met.
•Local forums where best practice is discussed were not attended by the Provider / Registered Manager or any other representative of the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Following the inspection, we were advised the deputy manager had been in contact with the local authority to seek support and guidance.

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

•Staff told us the registered manager visited every week but there was no recorded evidence of visits. The deputy manager knew people well. However, the service was insular. Regular feedback from visiting professionals was not sought.
•People were not partners in their care or involved in service developments.
•There was no evidence of regular involvement with staff in discussing how the service could be improved or support their well-being.

Working in partnership with others

•The service did not have close working relationships with mental health staff, learning disability support services or the local authority at the time of the inspection.
•We referred our concerns to the local authority following the inspection.
•The deputy manager listened to our inspection feedback and started to address our immediate concerns. They also contacted the local authority improvement team for support.