Quest Haven Limited

Quest Haven Limited - 31 High Street

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Quest Haven – 31 High Street 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. Quest Haven – 31 High Street provides residential care for 5 people with learning disabilities. At the time of our inspection there were 3 people living at the service who had a range of needs such mental health diagnoses and learning disabilities.

The care service has 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.

People's experience of using this service:
At our previous inspection in January 2019 we identified breaches of regulations of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service had not made improvements in all areas identified within our last inspection and people were still not receiving safe and effective care. This demonstrated the provider had not ensured all required improvements were actioned in a timely manner.

Relatives told us they felt their loved ones were safe at Quest Haven, but staff felt people were being put at risk due to there not being sufficient staffing levels to meet people's needs. Although staff were aware of their responsibility to safeguard people from abuse, safeguarding concerns were not always reported to the local authority or investigated internally. Risks assessments were either not correct or guidance not followed by staff. The appropriate recruitment checks had been carried out for any new members of staff.

People's rights were not protected in line with the principles of the Mental Capacity Act 2005. The majority of staff were not up to date with mandatory training but received supervision on a regular basis. The service was not decorated in a homely manner and was sparse. Staff felt that the communication within the service was effective. Referrals to healthcare professionals were not always made when required.

Feedback from relatives and staff were that the service was kind and caring. However, we observed a lack of interaction between staff and people at the service. There was a lack of recording to demonstrate that people were involved in the decisions around their care. People were not treated with dignity and respect which effected their wellbeing. People were encouraged to be independent where possible.

Staffing levels affected people being able to go to activities that were important to them, and there was a lack of stimulating indoor activities within the service. The service had not received any complaints from relatives, but concerns raised by people were not taken seriously or acted upon. People's end of life wishes had not been discussed with people.

Staff felt supported by various levels of management within the service. Quality audits by the owner of the service were not robust and did not identify the issues we found on the day of the inspection. Records showed there was a lack of engagement from people and staff in the running of the service. Despite concerns raised in our previous inspection, there had been little improvements made by the registered manager and owner.

Rating at last inspection: At our last inspection we rated this service inadequate (report published on 16 February 2019).

Why we inspected: We brought forward this inspection due to ongoing concerns around safe care and treatment, record keeping and staffing.

Enforcement: We identified seven breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of The Health and Social Care Act 2008 (Registrations) Regulations 2009. 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. We have made a recommendation about the use of pictorial menus for people.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not 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.

Quest Haven Limited - 31 High Street

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 team consisted of two inspectors.

Service and service type:
Quest Haven – 31 High Street 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:
The inspection was unannounced.

What we did:
Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at our inspection

During the inspection, we spoke briefly with two people who lived at the service due to their cognitive impairment. We also spoke two staff members including the registered manager who is also the provider of the service. We reviewed a range of documents including two care plans, three staff recruitment files, medication administration records, accident and incidents records, policies and procedures and internal audits that had been completed. Following the inspection, we spoke with one relative and two staff by telephone.

Inadequate

Is the service safe?

Our findings

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

At our last inspection on 4 January 2019 we identified breaches of regulations 12, 13, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the failure to ensure risks to people were appropriately managed and safe care and treatment was provided, a sufficient number of suitable staff were employed to meet people's needs, and safeguarding concerns were reported and investigated appropriately. At this inspection we found that improvements had not been made in the majority of these areas.

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

Assessing risk, safety monitoring and management

● Risks to people were not appropriately recorded or managed. One person was at risk of choking. Their risk assessment stated that staff should encourage them to eat slowly and chew properly. There had been no referral to the Speech and Language Team (SALT) to ensure that their nutritional needs were being safely met. The same person also had a risk assessment around smoking, which stated that they should never be in possession of their lighter and staff should keep this safe. However, we observed in records that the person had been found smoking in their room on numerous occasions. Therefore, their risk assessments were not being managed appropriately to by staff to ensure people's safety.

● Another person was at risk of eating uncooked food due to their medical condition and cognition. However, we found raw food in the fridge they were able to access. Therefore, management of this risk had not been identified or resolved, such as the food being put in a lockable storage box within the fridge.

● The provider's physical intervention policy stated that people should have a written behaviour management plan. These help staff understand how to support people during different stages of behaviours. However, people's care plans did not contain these. When we informed the registered manager, he was not aware what behaviour management plans were.

● There was an unconfident approach within the service in helping people understand their bodies and relationships. All risk assessments around this reminded staff to supervise, observe and distract people from expressing this behaviour. There was no information, guidance or suggestion that staff should accept, monitor or talk to people around this area of their lives. This had led to behaviours around this not being managed appropriately. One staff member said, "When I take a particular person out in the community (they) touches people inappropriately. It feels embarrassing and unsafe. If I had another staff member it would be easier to manage."

● The service had a business continuity plan in place. This gives instructions on what action should be taken in an emergency, such as a loss of accommodation or travel disruption. However, the policy stated the service should have a flood kit, including items such as important documents, a torch, a first aid kit and blankets. We asked the registered manager to show us the kit but were told that they did not have one.

● There were no personal emergency evacuation plans (PEEPs) or missing person's profiles in place for people. We had informed the registered manager of this during our last inspection. This left people at risk in the event of an emergency. We informed the registered manager of this who replied, "We don't have PEEPs

or missing person's profiles. We didn't know that they were required." Following the inspection, the registered manager forwarded what he believed to be PEEPS to us by email, but these were copies of the business continuity plan.

● Window restrictors had been fitted to ensure people's safety. However, other aspects of the environment were unsafe. An emergency call bell in one of the toilets was tied up to a level that would make it unusable in the event of an emergency.

Using medicines safely

● Medicine administration and recording practices were not safe. One prescription of medicine to treat insomnia had not been given to the person for a week. The medicine was not available in the medicine cabinet. There was no information as to why this hadn't been administered for a week. When we informed the registered manager and staff member, they were to tell us why. The service's medicine policy stated, "Records of doses omitted or refused must be clearly maintained on the medication administration record (MAR)." This therefore meant that the service was not adhering to its medicine policy.

● The medicine cabinet had a thermometer in to monitor the temperature and ensure medicine was stored appropriately. However, there was nothing to advise staff what the maximum temperature was and what action to take if it exceeded this.

● A recent external medicines audit identified people's photographs of them on their medicine profile were out of date, and as and when (PRN) medicine protocols did not contain personalised information on how people like to take their medicines. It also identified some prescriptions were handwritten on to MAR charts but not double signed by two staff members which was not in line with national guidance. These issues had not been resolved on our inspection and we continued to find these shortfalls. We asked the registered manager why this had not been addressed. They said, "I did not know we had had a recent audit."

Preventing and controlling infection

● Staff told us that they adhered to infection control policies. One staff member said, "We have aprons and gloves. We always use them. Without the gloves it would pointless. There is always a stock of them."

● However, despite this we observed that cleaning equipment such as mops and buckets were left outside on the garden floor. We had asked the registered manager to address this on our last inspection.

● Although there were no malodours, areas of the service were unclean. The conservatory floor was sticky and the table was covered in food and water on our arrival, despite people having finished their breakfast some time before we arrived.

Learning lessons when things go wrong

● There was an accident and incident book for staff to complete. However, we found that not all incidents had been reported in the book. For example, we found other accident and incidents noted in people's care plans and in books created for each person where staff could note down any negative feedback or statements they said.

● Incidents reported in the book or people's care plans did not always show what action had been taken to prevent this from happening again. For example, one person became agitated with staff as he wanted to smoke inside due to bad weather. There was no consideration of how to stop this from happening in the future, such as installing a sheltered smoking area or offering them an umbrella.

● There was no analysis of incidents to identify trends and prevent people from avoidable harm in the future.

The failure to manage the risks associated with people's care including medicines and infection control is a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff were aware of safeguarding policies and procedures. One staff member told us, "I would need to call my manager first, and then the senior manager." Another staff member said, "There is an incident book in place and we inform the manager. He should then inform safeguarding. We've had training on how to raise safeguardings now so any of us can do this". Despite this, safeguarding concerns were not being reported correctly.

● Records showed concerns had not always been made to the safeguarding team where appropriate, and full investigations of incidents had not been carried out. This included allegations of abuse. We have asked the registered manager to liaise with the safeguarding team to ensure that all concerns have been reported and the correct action taken to ensure people's safety.

The lack of reporting safeguarding concerns to the correct authority meant that people were still at risk of abuse. This was a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Relatives told us they felt their loved ones were safe. One relative said, "I feel he's safe there. We've always had a good rapport with the staff. The only shame is their staff turnover." However, feedback from staff was they felt unsafe in the service. One staff member told us, "Sometimes I feel very good there and sometimes it's harder. I find it difficult as the people want our attention all the time and there is not enough of us. I have felt unsafe when it was just me there. Especially out in the community. One time I took them to the pub by myself. I found it very difficult."

● There were not sufficient numbers of staff to safely meet people's needs. A relative said, "I think there's more staff than there was before, but most of the time there is only one member of staff." One staff member told us, "We use agency staff now. They know what they are doing as they are learning disability trained. I worked with them for a bit before I went home." Another staff member said, "We have been short staffed. We've had problems taking the people out in to the community and we've been working long long hours." The registered manager told us, "You're right, there isn't enough staff and I am concerned about this. Some of our staff members are not telling me until the day before that they are not turning up."

● Staff and the registered manager did not know which staff were working on the day of our inspection. When we arrived, we were told by staff that an agency worker would be starting at 11am which would allow them to support a person to their dental appointment. The registered manager then told us that it was a new permanent member of staff rather than an agency worker. They told us, "You're right. We thought someone was coming and they aren't." The second staff member never arrived, and the registered manager later told us that they were starting at 3pm, but later changed this to say it was a different permanent staff member. The second staff member had still not arrived when we left the service at 4pm.

● Rotas showed that service had not improved their staffing levels since our last inspection. Since our last inspection, there had still been only one staff member to care for people up until the day of our inspection. However, these records were not accurate as described above. People were still not able to stay at their home if they wished due to there not being enough staff to allow for this as well as transporting people to day centres during the week. They were therefore expected to go to the service's other home in this time.

The service was still failing to provide a sufficient number of staff to meet people's needs safely. This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff files evidenced that staff had been recruited safely. This included a Disclosure and Barring Service (DBS) check, written references and a full employment history.

Inadequate

Is the service effective?

Our findings

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

At our last inspection on 4 January 2019 we identified breaches of regulations 11 and 18 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the failure to provide staff with relevant and effective training, supervision and appraisals. At this inspection we found that improvements had not been made in these areas.

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

Staff support: induction, training, skills and experience

- One relative said, "The staff seem to all know what they're doing." A staff member told us about their training and said, "I've got two modules more to do. The ones about dementia and safeguarding was very interesting." Another staff member said, "I've done all of my mandatory training now, I found it useful."
- Despite this staff were not up to date with their mandatory training. Only two staff members had completed and were up to date with the service's mandatory training. Despite the service providing support for people with a mental health diagnosis, less than half of staff members had completed this mandatory training module. The service had not always provided staff with their own companies training modules and had allowed them to transfer their training from other providers. This meant that staff members may not be aware of the service's own policies and processes in certain training modules.
- Staff received regular supervisions. However, these were not effective as they did not identify the shortfalls in staff competencies around safe care and treatment and treating people with respect. Records of these meetings was difficult to read and often illegible. One member of staff said, "I have supervision every six months but they've changed it to three months now. It's good because I find these meetings are helpful."

The service was still failing to provide effective training, supervision and appraisals. This was a further continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care

- People were not always supported to maintain their nutritional and hydrational needs. One person told us, "I'm only allowed fruit at lunch time." We observed two documents that a person attempted to 'steal' fruit at breakfast time. We asked the registered manager to comment on this, to which they said that people should be allowed fruit throughout the day and they would inform staff of this.
- There was no menu available for people. Staff had created a schedule in a book detailing what was for dinner each day. However, this did not show another option for a meal if a person did not like the main choice, nor did it show what was available for breakfast or lunch. A pictorial menu was not available for people which could have been beneficial for them. A quality assurance manager from the local authority

had suggested this be implemented a couple of months before our inspection, but this had not yet been completed.
● People told us that they enjoyed their lunch. One person said, "I had a sandwich and some soup, it was lovely." However, often meals were not freshly made and were from a tin, such as macaroni cheese.

We recommended that the service implement a pictorial menu for people.

● Relatives felt communication within the service was not very effective. A relative told us, "They don't update me on what [my relative] has been up to, so I have to rely on [my relative] to tell me." However, staff felt communication was effective. A staff member said, "We use a communication book for any to do messages and we pass over verbally too." Another staff member said, "The communication is okay. We use the book and make sure we read it every day. If it's important we make sure we call the manager or deputy."
● The communication book used by staff contained very basic information that was consistently repeated. For example, multiple entries stated 'gave medicines, no concerns at the time of writing this report, household chores done.' A lack of detail meant that it would be unclear for staff what household tasks had been completed or if anyone had missed any medicines in this example. One entry in the communications book in February 2019 asked staff to photograph food and meals made so that a picture menu could be created. This was not completed on the day of our inspection.

Adapting service, design, decoration to meet people's needs
● The service was not decorated in a homely manner. There was a lack of decoration or furnishing to make the property feel like people's home.
● One person had asked for posters to decorate and personalise their room. This had not happened on the day of the inspection. We have been informed since the inspection that the person has now received posters for their room.

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Referrals to healthcare professionals were not completed where required, leaving people at risk. People's care plans showed that they had been suffering from ear wax and bleeding gums, but there was no information as to what action had been taken from this. When we asked the registered manager he said, "I didn't know about this. I will get them both checked. Staff inform me of this normally."
● One person's mental health had deteriorated and required professional input. However, no referral to the community mental health team or GP had been made. One staff member said, "He says that he's depressed a lot but we just wait until he sees the psychiatrist next." We asked the registered manager to make this referral straight away. This person has now received an appointment with the health professionals they require.
● Although people and staff informed us that they had seen the dentist last week, documents recording visits to healthcare professionals were not completed to show this.
● People did not receive care in line with national guidance or the law. This included care around nutritional needs, safeguarding referrals and medicine administration and recording.
● People had a hospital passport in place. This document could be taken to hospital with a person to inform staff of their health and care needs. However, the information did not always match the information in people's care plans. For example, one person's hospital care plan did not record that they had a mental health diagnosis.
● No new people had moved in to the service since our last inspection, so we did not review pre-assessment documentation.

The service failed to provide care that was personalised and reactive to people's needs. This was a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● People's legal rights were not protected because staff did not follow or were not aware of the principles of the MCA. A staff member told us, "We shouldn't assume a person hasn't capacity unless its proven, and we should allow them to do as much as possible. Everyone should have DoLS at 31 High Street." Another staff member said, "I've had training on it, but I can't remember it very well. I think people who lack capacity include those with dementia."
● Decision specific mental capacity assessments had not been completed where people lacked capacity. Some people did not have capacity assessments for decisions such as consent to care and medicines, and others had capacity assessments for multiple decisions. Best interest meetings had not been completed following this to ensure that they least restrictive option was chosen for that person.
● DoLS applications had not always been completed for people who required the. Applications that had been completed did not explain the restrictions that had been put on that person.
● One person was at risk of leaving the service unaccompanied and required a DoLS for restricting their liberty to do this. However, the back door and back gate was left open for the entirety of our inspection, even whilst the person was in the garden unsupervised. This left the person at risk without the correct restriction being put in place for them to ensure their safety.

The failure to follow the principles of the Mental Capacity Act 2005 meant that people's rights were still not protected. This was a continued breach of Regulation 11 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

At our last inspection on 4 January 2019 we identified a breach of regulation 10 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the failure to provide dignified and respectful care to people. At this inspection we found that improvements had not been made in this area.

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

Ensuring people are well treated and supported; equality and diversity

- Relatives told us staff were kind and caring. One relative said, "I've spoken to a few different staff on the phone and they speak to [my relative] in a caring way." Staff also felt that they had a caring team. One staff member said, "I think everyone is caring at 31 High Street."
- Despite this feedback we found aspects of the care were not caring. One person's risk assessment stated that if this person were to vomit from choking, they should clean up their own vomit to understand what they did. Staff did not interact with people. We observed staff members and the registered manager sitting in the lounge on their mobile phones rather than engaging with people in the room. Throughout the day, people came to sit and talk with us due to a lack of stimulation from staff. One person said, "I just want somebody to talk to." Staff would then inform them that they could not sit with us but gave no reasoning for this. When the registered manager told a person to leave the room we were sitting in, he said, "I don't want him wasting your time here." This showed a lack of respect towards people.

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

- People were involved in planning care where possible. People's families were also involved in this process.

- People told us they had been involved in some of the planning of their care. One person told us that he recently attended a review with his family, social worker and the registered manager. Their relative told us, "We recently attended a review with [my relative] and his social worker. He fully participated in the process." However, an issue was raised within this meeting regarding a staff member which had not been followed up appropriately by the registered manager. This meant that people were not supported to express their views and concerns.
- There were no documents to reflect that people had been involved in their care planning. We informed the registered manager who said, "I understand that you need to see that people are involved in the care plans. Mandatory reviews are completed with them and their care managers. Call families or social workers – they will tell you at the review we covered this and they were involved." Despite the registered manager saying that he understood the need to evidence this, there were no records to support this.

Respecting and promoting people's privacy, dignity and independence

● People's dignity was not respected, and staff did not treat them as equals. The culture of the service was that people were 'done to' rather than treated with respect. During the inspection, one person became upset. They informed us that they wanted to bath because they felt dirty. The person said, "It doesn't make me feel nice when they don't help me. I told [the registered manager] and care worker but they didn't help me." When we asked the registered manager about this, he informed us that a staff member would be in two hours later who would be able to do this for him. We asked the registered manager to help this person with their personal care immediately. The person's mood increased after this, and they were much happier which showed in their body language. During feedback we raised this with the registered manager who said, "[The person] can bath himself, he doesn't need me." This therefore contradicted the information given to us earlier in the day, and we observed that the person was requesting support to fulfil this need.

●People appeared unkempt, wearing dirty clothing that didn't fit them. Two people's trousers were extremely large and were being held up by belts. The jumper one of them was wearing was also covered in stains and food. The person told us, "We get clothes from the charity shop."

● People told us that staff respected their privacy and independence where possible. One person told us, "The staff knock on the door if I am having a bath." They went on to confirm, "I cut the potatoes for dinner, and [another person] makes the salad." We observed there was now a working lock on the bathroom door that was absent at our previous inspection.

● Staff told us they respected people's dignity and independence. One staff member said, "We have to respect their dignity when they're dressing by closing the door or windows. We have to ask them if they feel comfortable with us. If not, I wait outside the door." Another staff member said, "We should encourage people to do as much as possible. [One person] does the hoovering and changes his bed, [another person] does the washing up, and [another person] likes to be involved in the cooking."

The service failed to treat people with dignity and respect. This was a continued breach of Regulation 10 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

At our last inspection on 4 January 2019 we identified breaches of regulations 9 and 16 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the failure to provide personalised care and ensure that complaints were dealt with appropriately. At this inspection we found that improvements had not been made in these areas.

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

● Relatives and staff felt that there was not enough engagement and activities for people living at 31 High Street. A relative said, "[A previous staff member] used to take him all over the place. I'm really not sure about the other staff and what they do with him. He was supposed to be going to a disco but one of the other people living there didn't want to go which meant none of them could." A staff member said, "We need more activities in the house. TV and music are not enough. I think we should have board games and things like that. Then it will be easier to take care of them and improve communication between people." Another staff member told us, "If there is only one staff member it means that people can't always do what they want to do. It would be good to buy a table tennis table for them to get them engaged."

● People told us they were supported to access activities in the community. One person told us, "I go bowling every Tuesday, and I go swimming every week with a staff member too." Another person told us, "I enjoyed going to the pub." However, the staffing rota contradicted the activity rota, as there would not have been enough staff present on a daily basis to provide the support needed for people to attend their activities. For example, on Friday mornings one person required one to one support to attend basketball, and another person required support to go to the bank and go shopping. However, there was only one staff member on the rota for Fridays, meaning this would not be possible. The registered manager said that the activity rota demonstrated what they are aiming for when they have more staff to facilitate it.

● There was a lack of meaningful activities happening within the service. The main activity within the service was the television, and people were not engaged to take part in other activities that may interest them.

● People did not receive person centred care. Care plans did not included details such as people's background, likes, interests and friendships. Daily notes contained basic information and no personalised information as to what activities people had enjoyed or interesting conversations had that day. The registered manager said, "I don't have any information about them for person centred info in their care plans and I don't know where I would get that."

End of life care and support

● Care plans did not contain any end of life information. This meant that if there was a sudden decline in somebody's health, the service would not be aware of their last wishes to be able to carry these out. Although this was raised at our previous inspection, the registered manager said, "I wasn't aware we needed end of life care plans."

The service failed to provide care that was personalised to people's needs. This was a continued 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

● Relatives felt unsure if their or their loved one's complaints would be taken seriously. A relative said, "I've not had to make a complaint recently. I would hope it would take it seriously. However, when [my family member] raised a concern I don't think the manager took him seriously."

● The service had received no complaints, and there was a policy in place to support people in raising a concern if required. However, people's concerns were not dealt with appropriately. One person had raised a concern about a previous member of staff which had not been investigated by the registered manager. We informed him that this must be investigated correctly during our inspection, and we are awaiting the outcome from this.

● Each person had an 'unwelcome utterances' book, which people's concerns were recorded by staff. However, no action was taken from this book. One staff member said, "It's used for [one person] mainly when he says something offensive." Another staff member said, "If anyone says anything they are concerned about we write it in the unwelcome utterance book. We tell the next staff member so that they are aware and we call the manager. I'm not sure what happens after that though." The registered manager said, "We started these books to protect staff if somebody says something that isn't true. One person says things that that aren't true. He has said things that are wrong before." This meant that people couldn't be confident that their concerns would be taken seriously and acted upon.

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 our previous on 4 January 2019 we identified a breach of regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the governance of the service. This related to a lack of management oversight of the service and the failure to ensure robust auditing processes were in place to identify and improve any shortfalls in the service. In addition, at our last inspection we found the provider had failed to report all notifiable incidents to CQC in line with their statutory responsibilities. At this inspection we found that improvements had not been made throughout the service.

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.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- People and relatives felt the manager was approachable but not proactive. One person said, "The registered manager is nice yes. He talks to me," A relative said, "I haven't got any problems with him. He can be a little too laid back. I feel that there have been some improvements. I think they all need to pull their socks up."
- Staff felt supported in their roles and listened to by the registered manager. One staff member told us, "He is a good manager, and so is [the deputy manager]. I feel supported and valued by them." Another staff member said, "The management team are doing their best. I would say they've put a lot of work into the care plans."
- There had been a lack of improvements made since our last inspection. We issued three warning notices at our last inspection in relation to the failure to provide safe care and treatment, staffing and good governance and oversight of the service, which had not been met. Following our inspection on 4 January 2019, the registered manager provided us with an action plan stating that they would make improvements to meet the regulations. However, they had not done this at this inspection. The registered manager required more support to be able to implement the improvements needed to the service. He said, "There is only me, I need help. I'm not taking anything you say as negative."

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

- People told us they were involved in the running of their home. One person said, "We have a menu meeting every week." However, these meetings were not documented other than a book stating what dish was for dinner each day of the week. It was unclear how the choices were reached.
- There were monthly service user meetings. Minutes from the meetings were not detailed and did not show how people were involved in improving the service. For example, people were asked in a regular meeting if they were happy. The meeting notes said, "All appear to be happy with their lot as didn't have much to say." Therefore, there was a lack of engagement with people within meetings to find out their opinions and views.

● Staff meetings also lacked engagement. A staff member told us, "We used to have staff meeting every three months, but in the last month we've had two staff meetings. If someone couldn't attend they are asked to read the meeting minutes book." Minutes from a recent staff meeting shows that staff were told about the latest CQC inspection and what they plan to do next. However, it did not note any staff members reactions or feedback from this meeting.

Working in partnership with others
● The service had started to look to engage with outside organisations. There were plans in place for people to start attending a local disco this month. However, there had been no engagement with organisations that could offer in-house activities or entertainment for people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● Quality audits did not identify issues which we found during our inspection. A recent internal audit completed by the owner of the service stated that he was unsure if the safeguarding concerns were being reported to the local authority and CQC. In the audit, the owner stated, "I will discuss this with the manager and deputy manager, so that it is done immediately when relevant." However, we found evidence that some safeguarding concerns were still not being reported.
● The registered manager who is also the provider of the service, was not displaying the service's latest rating which is a legal requirement. When we asked them about this, they said, "I haven't got round to doing this yet." The audits had also not picked up the issues we found around medicines, risk management and interaction and engagement in the service.
● The service's record keeping policy says that "Individual and home records are kept in a secure fashion, are up dated and in good order." However, we found that a lot of records will still not reflecting up to date information, and where handwritten the writing was often illegible.
● The registered manager had failed to report notifiable incidents to CQC in line with their regulatory requirements. This included altercations between service users resulting in physical injuries and safeguarding concerns around allegations made about members of staff.

The lack of robust quality assurance meant people were still at risk of receiving poor quality care. The provider's systems had failed to identify issues effectively. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service failed to notify the Care Quality Commission of all notifiable incidents so that appropriate risk levels could be determined. This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Registrations) Regulations 2009.

The service failed to display their latest performance assessment. This was a breach of Regulation 20a of The Health and Social Care Act 2008 (Registrations) Regulations 2009. We informed the registered manager of this who is now displaying the correct rating within the service.