Quest Haven Limited

Quest Haven Limited - 31 High Street

Inspection report

Horsell Village
Woking
Surrey
GU21 4UR

Tel: 01483757995
Website: www.quest-haven.com

Date of inspection visit:
27 August 2019

Date of publication:
28 October 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:
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 five people with learning disabilities. At the time of our inspection there were three people living at the service who had a range of needs such as mental health diagnoses and learning disabilities. During the inspection, the registered manager informed us that one person would be moving to another service. The person has now left the service at the time of publication of this report.

People's experience of using this service:
At our previous inspection in April 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. This demonstrated the provider had not ensured all required improvements were actioned in a timely manner.

The service did not apply the full range of the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support due to lack of choice and control and limited inclusion.

Relatives did not always feel their family members were safe, and risks to people were not being appropriately managed or recorded. Medicine administration and recording procedures were not safe, and staffing levels did not meet the requirements set out in people's care plans.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Relatives and health professionals had not been involved in best interest decisions for people. Staff were not up to date with training, and supervisions were ineffective. The environment was dirty and unclean. People were not supported to maintain a healthy nutritious diet and advice from health professionals was not always followed which impacted on their health.

There was a lack of interaction between staff and people at the service, and people were not always involved in the decisions around their care. People were not treated with dignity and respect and were supported to build relationships with visitors to the service. There was an inconsistent approach to supporting people to take part in meaningful activities and holidays. Staff did not know people's backgrounds, needs and medical history.

Despite the registered manager feeling they had made improvements, we identified continued issues that required addressing. There was a lack of management oversight as the registered manager was only at the service one day a week. Staff did not feel supported by the registered manager. Internal and external quality audits were not effective in their use as they did not identify the issues we found on the day, and any issues that had been identified had not been rectified. People, relatives and staff were not engaged with the running of the service.

The appropriate recruitment checks had been carried out for any new members of staff. Relatives had been asked to support with completing end of life care plans, but none had been finished on the day of our inspection.

Rating at last inspection: At our last inspection we rated this service inadequate (report published on 3 September 2019).

Why we inspected: We inspected this service in line with our inspection scheduling based on the service's previous rating.

Enforcement:
We identified eight 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 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.

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?

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 before the inspection
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 and observed interactions staff interactions with people. We also spoke with 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, four staff recruitment files, medication administration records, accident and incidents records, policies and procedures and internal audits that had been completed.

After the inspection
Following the inspection, we spoke with two relatives, one staff member and a staff member from the local day centre 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same. At our last inspection on 3 April 2019 we identified a breach of regulations 12, 13, 18 and 19 of the 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.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people's health and safety continued to be inappropriately recorded and managed. One person's care plan stated they were at risk of leaving the service unaccompanied, and therefore all doors should be locked. However, during our inspection, the person opened the unlocked front door and walked out of it without a staff member supervising. If the person had gone missing, the information in their missing person's profiles which helps emergency services find and identify a missing person was incorrect. The document included an incorrect physical description of the person', did not contain information around medicines they were on and did not state where they could most likely be found. This left people at risk of not receiving the correct support in an emergency.

● People were at risk of harm because staff had not followed guidance to support people with behaviours that may challenge. One person was at risk of self-harm, and a recent report from the community mental health team suggested all knives were locked away. However, people were able to open a kitchen drawer where large kitchen knives were accessible. When we raised this with the registered manager, they said, "They are just suggestions." The person's relative told us, "I don't believe they were managing the risks at all." Another person was at risk of displaying challenging behaviours. Their risk assessment stated they may hit others and bang their head. However, there was no information on what the possible triggers of this behaviour may be or how they behave they are becoming agitated. When we asked a staff member about this, they told us, "I know he needs support. I don't know the specifics."

● People's safety could not be assured in an emergency. Personal emergency evacuation plans (PEEPs) did not contain information vital to supporting people in an emergency. For example, one person's care plan stated they reacted badly to loud sounds. However, their PEEP was generic and did not include this information.

● 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.

●We raised the lack of improvement in assessing and monitoring risk to the registered manager. They informed us, "I am frustrated you are finding issues. I'm not saying we're perfect, but we've improved." Therefore, they were unaware they were still not ensuring people's safety.

Using medicines safely

● Medicine administration and recording practices were not safe. One person who attended a day centre throughout the week required a medicine to be administered at lunch. The registered manager explained the day centre administered the medicine, but they were not clear on how this was managed. There was no record on the medicine administration record (MAR) chart to explain this was arranged with the day centre. When we spoke to a staff member at the day centre following the inspection, they told us, "We give him his medicine here. We tell the service it needs to come in the box with his prescription on, and there's never been a problem with us receiving it. We fill in a MAR but they never ask for it or any confirmation that he's had the medicine. They wouldn't be aware if he didn't have it one day – they never ask." Therefore, the service had not ensured there was a clear procedure to confirm the person had received and taken their lunch time medicine.

● People's medicines were not stored safely. The medicine cabinet had a thermometer in to monitor the temperature and ensure medicine was being stored appropriately. There was also guidance on the fridge to advise staff of what the maximum temperature was. However, the cabinet had exceeded its maximum temperature and staff had not noticed this or taken any action to reduce the temperature and protect the integrity of the medicine. Creamed medicines did not have opening dates on them, meaning staff would not be aware of when they were not fit to use any longer. There were no body maps in place to show staff where to apply creamed medicines to a person's body. Guidance for as and when medicines (PRN) did not include information on what signs to look for when people were in pain.

● Some staff members had not received medicine competency checks which had consequently affected the safety of medicine administration and recording. Hand written entries to medicine administration record (MAR) charts had not been countersigned by a second staff member to ensure the information written was correct. We raised this with the registered manager who said, "You're right, you're right. They should be doing that." One staff member told us they had not received a medicine competency check on their return to work after not administering medicines for 11 months. Despite this, the staff member told us they had been administering people's medicines since their return, they had not signed a document indicating they were aware of the principles of administering medicines. When we asked them, they were unable to tell us which medicines were used to treat a person's anxiety and were also not aware how often it should be given to the person. This left the person at risk of receiving too much medicine or the medicine being used inappropriately.

Learning lessons when things go wrong

● People were at continued risk of harm because accidents and incidents were not managed in a safe way to prevent a reoccurrence. Whilst there was an accident and incident book for staff to complete, we found other incidents recorded in the staff communication book and in the safeguarding log. Therefore, there was no central location for incidents so any trends could not be identified and analysed.

● Records of accidents and incidents did not always show what action had been taken to prevent reoccurrence. One person had tripped over a door threshold when walking outside the back door of the service. Another person had also cut themselves with a knife. While these accidents and incidents were recorded, there was no information on whether the registered manager had taken any steps to prevent this from happening again, such as putting distinctive edging on the door threshold to make people aware of the need to step over it.

● Two people living at the service were having regular altercations leading to small injuries. As these were repeated incidents, it demonstrated that sufficient steps had not been taken to learn lessons where things had gone wrong.

Preventing and controlling infection

● We observed both good and poor infection control practice by staff. We observed a staff member wearing

gloves when preparing food. 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, we also observed the registered manager walking around the service bare footed which could spread infection.
The failure to manage the risks associated with people's care including medicines is a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were at risk of harm because the environment was dirty and unhygienic. Some of the issues we identified were the kitchen surfaces were covered in grime, shower heads were dirty, the bottom of the laundry bin was thick with dust and dirt and we found blood stains on walls and cloths around the service. Furniture was also worn and stained, as well as general cleanliness levels being poor. When we informed the registered manager of our findings he said, "The garden does need doing, but I didn't know that [the service was dirty]."

The failure to ensure the environment was clean and hygienic was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were at risk because staff did not fully understand their roles and responsibilities around protecting them from abuse. One staff member told us, "Safeguarding could be sexual abuse, neglect, physical. It could be staff, family or people. Hitting would be abuse. I would report it to the manager." However, they were not aware that it should also be reported to the local authority too. Another staff member said, "I'd speak to my manager, and tell the safeguarding team". Despite this, safeguarding concerns were not being reported correctly.
● Records showed safeguarding concerns had not always been appropriately followed up. One safeguarding concern stated a person at high risk of injury had been pushed over by another person. Despite the person complaining of pain, the registered manager and staff had failed to seek medical attention for them following the incident, until a social care professional visited and instructed them to do so. There was no information recorded as to what action had been taken to prevent reoccurrence, and there had been another incident between the same two people the day before our inspection. This resulted in one person receiving a cut on their forehead. This left people at risk of ongoing harm. Since the inspection, we have been informed that one of the people involved in the incident has moved to another service.
● When we raised our concerns with the registered manager about not informing us of incidents without prompting from other authorities so we can check that appropriate actions have been taken, they told us, "As far as I'm concerned, whatever has happened I make sure I send it to you and cascade it to all the other people."
● Relatives gave us mixed feedback on the safety of people. One relative said, "I didn't feel he was safe. I was getting phone calls for most of this year saying there had been incidents with another resident and one of the carers had hit him. Altogether it didn't sound safe at all." However, another relative told us, "We don't get to see [our family member] very often, but they call us if there is a problem. It's a lovely home. It's a welcoming home."

Failure to have systems in place to safeguard people from abuse 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 there were sufficient staffing levels at the service. One relative told us, "I do feel there is enough staff. However, there's been a lot of staff coming and going." One staff member told us, "I

work with a lot of agency and it takes time to have to explain the job to them. Some are good. You have to go over a lot of things." Another staff member said, "I think we need more staff, but only as two staff members recently left."

● Despite the registered manager telling us they had improving staffing levels since our last inspection, there were still insufficient staffing levels that did not reflect the care required to meet people's needs. The registered manager said, "We always make sure we've got two staff on. When I have two staff on, one staff member is only with [one person], and the other is with the other service users. [The one person who requires one to one] wakes up later so we don't have issues in the morning." However, another person's care plan also stated that they should 'always have one to one'. This therefore meant that two staff would be providing one to one care to two people at the service, leaving the other person who lived there without support. When we arrived at the service, there was one member of staff looking after two people, one of whom the registered manager informed us required one to one care.

● Other documents viewed demonstrated people who required one to one care were not receiving it. An entry in the staff handover book stated one member of staff had taken both people who require one to one care to a local pub for a meal. Therefore, there was not adequate staffing to ensure that people's needs were met, and risks were managed in the community.

● Staff deployment had not been managed to ensure people were safe. Staff and the registered manager were unaware of how staff should be deployed on the day of our inspection which was an issue we identified during our last inspection. An agency member of staff arrived at the service later into our inspection. Both them and the permanent member of staff already there were confused as they believed they should have been at the provider's other service, but the registered manager told them to stay. When we checked the rota for the day of the inspection, a different permanent member of staff was due to be working that day. The registered manager informed us this member of staff was working at the provider's other service today. Therefore, staffing rotas were not being accurately recorded.

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.

● Recruitment files evidenced staff had been recruited safely. Staff's files included a full employment history, references from previous employers and a Disclosure Barring Service (DBS) check. This ensures that people are safe to work with vulnerable people.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes. At our last inspection on 3 April 2019 we identified a breach of regulations 11 and 18 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 and to work within the principles of the Mental Capacity Act (MCA). At this inspection we found that improvements had not been made in these areas.

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 when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's legal rights were still not protected because staff did not follow or were not aware of the principles of the MCA. A staff member told us, "They can either be advantaged or disadvantaged. I don't know the five main principles of the MCA. I think you assume they haven't got capacity." Another staff member said, "Sometimes people have capacity and sometimes they don't. I've forgotten what mental capacity means and the principles are though." The lack of knowledge had impacted one person's rights. They had a mental capacity assessment which stated that they did not have capacity to consent to their medicines being administrated. However, when they had required a flu jab no mental capacity assessment or best interest decision had been completed for this.
● The recording of mental capacity assessments was variable which put them at risk of having their freedoms restricted illegally. One person's mental capacity care plan stated they had capacity to make all

decisions around their care even though the registered manager said, "He can't decide things by himself." However, they had mental capacity assessments for accommodation, finances and smoking in their care plan which stated they lacked capacity to make these decisions. The best interest decisions for all these assessments showed that no one had been consulted in deciding the least restrictive option for the person, such as family members, advocates or health professionals. Relatives confirmed this, with one relative telling us, "I have never been asked to be involved in this."

● DoLS applications should only be completed where people lack capacity. We found they had been completed for people who the registered manager had determined them to have capacity. One person's care plan stated they had capacity to make all the decisions around their care. Therefore, the registered manager and staff did not have knowledge of the MCA and DoLS.

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.

Staff support: induction, training, skills and experience

● There was mixed feedback from relatives and staff on the effectiveness of the training at the service. One relative said, "I feel staff absolutely know what they're doing." However, another relative said, "[Staff] said that somebody was monitoring [an ongoing risk for my family member involving behaviours that challenged], but it was still happening." A staff member told us, "Quest Haven have just sent me the links for infection control and lone working. It's all e-learning. Face to face training would be better as we can ask questions there and practice things."

● Staff were still not up to date with training. The registered manager told us, "All our training matrix, everything on there is done. Including safeguarding, mental health, dementia, and communication." However, the service's training matrix showed that no staff members had completed training in dignity and respect and record keeping, and only three out of 14 staff members had completed training in person centred care. The training matrix detailed one staff member had only completed medicine training from the pharmacy due to other training modules being covered in the care certificate, an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. However, when we asked the registered manager for the date the staff member had completed the this, he confirmed that they had not completed the care certificate. Their recruitment file also confirmed they had not completed the care certificate. Therefore, they had not received training in any of the other modules required by the service.

● Training was completed through e-learning courses. This included a first aid course, meaning that staff had not received practical skill training and checks in this area.

● Staff supervisions were not effective. One staff member's supervision record showed they had been updated on the importance of interacting with residents and stated they had 'good knowledge of our [residents]'. However, we observed the staff member not interacting with people throughout the day, and when we asked them about people's needs they were unable to tell us what these were. Furthermore, they were reminded of the importance of keeping the front door locked to keep people safe, but as described earlier in this report, we observed one person walk outside as it was left unlocked. The registered manager informed us, "Staff are getting supervision and appraisals. Every two months." However, the supervision matrix showed that staff were receiving supervision every four months and not receiving annual appraisals. Supervision records were still being handwritten and were often illegible.

The service was still failing to provide effective training, supervisions 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 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 completed where required. We saw evidence people had seen their GP and dentist recently. However, advice from healthcare professionals was not always followed. One person told us, "One of my teeth fell out the other night. It's because I have too many crisps." An entry into the communication book the month before said this person should be discouraged from having sugary and unhealthy snacks between meals. During our inspection we observed the person have a packet of crisps while waiting for their lunch to cook. Therefore, the guidance from the dentist had not been followed even though staff and management were aware of this. As stated earlier in this report, the service had also failed to follow guidance from a mental health professional to make knives inaccessible.

● Systems to ensure people received support that met their needs and preferences when they used other services, such as hospital, were not effective. 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 they had a mental health diagnosis. This could affect how they were cared for should they be admitted to hospital.

● People did not receive care in line with national guidance or the law. Care plans did not include nationally recognised assessment tools, such as the Abbey Pain Scale, an instrument designed to assist in the assessment of pain in people who are unable to clearly articulate their needs or Registering the Right Support (RRS). RRS guidance stipulates that people with a learning disability are as entitled to live an 'ordinary' life as any other citizen. However, people were not supported to do this by staff or the registered manager, due to a lack of meaningful life experiences and opportunities.

● No new people had moved in to the service since our last inspection, so we did not review pre assessment documentation.

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

● The service had started to improve the decoration of the service. Art work people had created were now on display in the living room. However, further work was required to fully embed this in all areas of the service.

● One person had asked for posters to decorate and personalise their room before our previous inspection. They had now received a poster, but it was extremely small, and no further decoration had been sought to decorate his bedroom.

The service failed to provide care that met people's personalised needs and follow health care professional's advice of treatment. This was a continued 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

● People were not always supported to maintain a healthy diet. One person informed the registered manager and a staff member they were hungry at 11:30am. Rather than offering them a healthy snack before lunch such as fruit, they were instead given a tin of ravioli and crisps. This was despite a pizza already being in the oven for their lunch, and guidance from the dentist that they should avoid crisps due to poor oral health.

● Pictorial menus were in place, as recommended on our last inspection. These were presented as set menus for the whole week. However, the registered manager also showed us minutes from weekly discussions with people on what they would like to eat for dinner each day for the following week. Therefore, the weekly pictorial menu did not always reflect what was being prepared for dinner each day.

● There was a lack of fresh foods available for people to prepare and eat. Kitchen cupboards were full of tinned meals and sauces. The day centre one of the people attended had recently raised concerns staff were

not supporting the person to bring in nutritious lunches, and instead were providing him with noodle pots or tinned soup which the person told centre workers they did not like. The person told centre workers he was not preparing his own lunch and was frequently requesting if he could share day centre staff's lunches. The day centre staff had requested improvements be made to the staff through the communication book and by email, but this had not been responded to.

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

● Relatives and staff felt communication within the service was not always effective. One relative told us, "Staff talk to one another when we're there. if there is anything serious they will ring me." However, another relative said, "They were very sketchy in coming to me with any information when [my family member] is ill or needing medical attention."

● Systems to ensure people received effective support across staff shifts was not effective. The communication book did not include the relevant information needed for staff to follow up on issues. When we arrived, a person told us they had tooth aches two days previously, which had led to their tooth falling out. However, this was not in the communication book. A staff member said, "Communication isn't very good. Staff don't pass on important information to me about [people] so I don't always know what's going on."

● Despite this, the registered manager felt there had been an improvement in this area. They told us, "Communication is better." Therefore, they had not identified the issues we found with communication on the day.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. At our last inspection on 3 April 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.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Relatives and staff gave mixed feedback around the kindness of staff. A staff member said, "Everyone is kind to people." One relative said, "They're kind and caring towards everyone. They always offer me a cup of tea when I arrive." Another relative said, "I don't get the impression these staff members are kind and caring. When a staff member was passing the phone over to [my family member] she was shouting at him to come to the phone. It sounded negative and aggressive. I remember thinking that's a little disturbing."
- We found aspects staff practice were not caring. Staff did not interact with people when sitting in the same room with them. We observed the registered manager and staff sitting in the lounge using their mobile phones rather than engaging with the people in the room.
- One person was keen to tell the registered manager they were making a pizza for lunch. The registered manager showed little interest in this and told them to go back in to the kitchen. When we raised this with the registered manager later in the day he told us, "He was doing an activity, so I wanted him to get back to it." We informed the manager that our concern was around the interaction and not activities, to which he replied, "I am surprised I responded in that way."
- Documents were not securely stored. Several books containing confidential information around safeguarding concerns and accidents and incidents were kept under a TV unit in the front room. This was accessible to anyone in the service and visitors. A large unlocked filing cabinet in the dining room kept archived paperwork in. The registered manager said, "It's okay because we don't use these records anymore." We explained any confidential information should be stored securely.
- The care provided to people was not safe, effective or responsive which impacted people's lives as outlined in this report. This was not indicative of a caring service.

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

- People and relatives were not always involved in reviews of their care. One relative said, "[My family member] is always at the table with us during the review. They always involve us." However, another relative said, "I have never been asked to be involved in this process."
- People were not always involved in making day to day decisions around their care. One person said, "I get to choose what I want for lunch and dinner and if I want a bath or shower." However, one person requested

to go out to buy a newspaper and new shoes. A staff member told us, "[Another staff member] told me to not let [the person] buy shoes. I didn't discuss this with [the person]." Therefore, they were not involved in this discussion and was not given a choice.

● There were no documents to reflect that people had been involved in their care planning.

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was not always respected. A relative told us that when they visited their family member, "Staff used to send [another person] to his room until we had gone." This did not allow the person to have freedom in their own household. However, we also received positive feedback, as one person told us, "The staff knock on the door if I am having a bath." One staff member said, "When they're in the toilet or in their room we must always knock on the door first."

● People and relatives told us staff respected their independence where possible. A relative said, "He makes his own cup of tea." A staff member said, "[One person] likes to help me clean, so I like to give him little things to do." We observed one staff member supporting a person to cut vegetables for lunch and ask them to put the food back in the fridge.

The service failed to treat people with dignity and respect and ensure that the privacy of the service user's personal information. 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. At our last inspection on 3 April 2019 we identified a breach 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 all these areas.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- There was an inconsistent approach to providing meaningful activities for people. A relative said, "[My family member] is out most days. They go bowling and to restaurants." A staff member said, "People know what they are doing now with activities." The registered manager had introduced picture boards showing the activities people had planned for the week. However, people were not always being supported to take part in activities or engaging experiences. One person said, "I'd like to try the local day centre. [The registered manager] keeps saying he'll arrange it soon." However, this had been promised to the person for several months. A relative said, "I never got told about any activities. He supposedly went out on his birthday, but I didn't get pictures of him out on for this." One person had been supported to go on holiday abroad with staff members. However, another person had not been fully supported to achieve this. The registered manager said, "[One person] was going to go away but thank god we didn't organise it and spend any money as he's now leaving [to live at another service]." Therefore, not all people were fully supported to live a normal life with meaning.
- There was a lack of meaningful activities happening within the service. The main activity was the television, and people were not engaged to take part in activities they were interested in, such as one person's interest around music. One person was due to receive their one to one activity hours on the day of our inspection. However, despite their being a staff member at the service to provide one to one care for them, they were not interacting with the person during this time.
- Staff did not know people well or their needs. When we asked a staff member to explain one person's needs and backgrounds to us, they were unable to tell us anything even though they said, "I read his care plan before." We asked another staff member about another person, who told us, "I haven't read anyone's care plan. I don't know the background. I know he has a mental disorder, but I don't know what it is." One person was not sure how old they were when we asked them. They looked to the registered manager for confirmation, who was unsure how old the person was and was unable to confirm this information to him.
- People did not receive person centred care. Care plans contained very limited information about people's backgrounds and did not always contain up to date information. For example, we observed a note in the service's diary from the GP advising that one person should not be using perfumed products or shower gel for personal care due to skin irritation. The person was not using perfumed products, but this was not updated in their care plan.

● Health action plans did not contain the information required for staff to care for people's medical needs appropriately. One person's health action care plan stated they have an allergy to pollen and to ensure the person had their inhaler on them. However, there was no information on how or when this should be given to him. One person had a condition which caused low bone density. There was no health action care plan around this. When we asked a staff member about what care the person needed because of this they said, "I don't know anything about this, but he isn't very strong."

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.

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.
● Communication care plans gave limited information on how staff should best support people with this. One person's care plan said the person could communicate by, "Talking to you, but he will draw for you if he can't tell you." However, it did not advise what they would find difficult to explain or whether their speech was limited which may impact how staff understand what they were trying to say.
● There was a lack of accessible information available to support people to understand day to day events and processes in the service. Staff had created picture activity boards for people, so they were aware what they would be doing each day. However, other easy read documents were not available, such as pictorial menus and complaints policy. This meant that people were not always given information in a way they could understand to make informed decisions.

End of life care and support
● The registered manager had contacted relatives requesting for input in creating end of life care plans. However, they had not received any response to this request on the day of our inspection. The registered manager said, "I've sent emails to relatives and am waiting for replies." However, this subject had not been approached with people at the service in the meantime to gather their opinions on this aspect of their care.

Improving care quality in response to complaints or concerns
● The service had a complaints book in place but had not received any complaints since our last inspection.
● One relative told us, "I've never had to complain. They have not given me anything to complain about." Another relative said, "I've never complained to the service."
● The service had an easy read complaints policy. However, this was not displayed in communal areas and was not easily accessible to people to advise them how to make a complaint if they needed to.
● 'Unwelcome utterances' books that we observed on our last inspection had now been removed from the service. These were books where concerns raised by people were recorded but we found that this had not prompted staff and the registered manager to follow up the concerns raised so were not serving their purpose.

We recommend that the service implements an easy read complaints procedure.

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 Inadequate. At this inspection this key question has remained the same. At our previous on 3 April 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. We found this area had not improved.

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.

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

- Relatives gave mixed feedback about the registered manager. One relative said, "He never really contacted me. I think I may have spoken to him once but that's it." However, another relative said, "[The registered manager] is always friendly. I get on really well with them all."
- Staff did not feel supported by the registered manager. One staff member told us, "He's alright. Not much else I can say" Another staff member said, "He's a good manager, but I don't feel I can go to him with any problems though."
- There had been a lack of improvements made since our last inspection such as care plans still being inaccurate, people not receiving personalised care and being at risk of harm, the principles of MCA 2005 not being followed and there being insufficient staff to meet people's needs. This was due to a lack of management oversight. Rotas showed the registered manager was only at the service one day a week.

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

- The registered manager was not aware of their regulatory responsibility to seek feedback from relatives on how the service was run. When we asked him if he had sought feedback from relatives, he informed us, "We've probably done them, I'm not sure. I think we do them before any care review, so we can discuss it at the meeting. It's CQC's role gather this for us." This was incorrect and did also not allow relatives the chance to provide feedback on the service.
- Residents meetings were not being held regularly. Only two meetings had occurred since our last inspection in April 2019 when they had been occurring monthly prior to this. Records of these were still being handwritten and were difficult to read. Steps were not always taken to improve issues raised in these meetings. For example, one person said that they did not like the food and asked if they could have something different. The registered manager informed the person they had already changed the menu and no further action was taken.

● There had only been one staff meeting since our last inspection in April 2019. Minutes from the meeting showed only two staff members attended as well as the management team. This meant that the majority of staff had not been included or updated on the discussions had in the meeting, which included the plans to improve the service.

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. An internal audit completed by the owner of the service in July 2019 stated, "All risk assessments have been completed and updated for each [person]." However, we identified risk assessments that were still required as described earlier in this report. A recent internal medicine audit completed by the registered manager had not identified the issues we found with medicine storage and administration.

● Areas for improvement that had been identified in quality audits had not been implemented. An external audit completed in June 2019 stated, "The registered manager has been asked to contact the families of each service user on a weekly basis via email to update how the week has gone and what each service user has been up to. This will then be printed and kept in the communications folder." However, this was not being completed. Therefore, internal and external audits were not effective in their use at driving continuous improvement and ensuring that people received care and support that met their needs.

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

● The registered manager had not always reported notifiable incidents to CQC in line with their regulatory requirements without prompting from other authorities. This included altercations between service users and safeguarding concerns. We had prompted the registered manager to send us the relevant notifications when other authorities had made us aware of incidents that had occurred. The registered manager told us," As far as I'm concerned, whatever has happened I make sure I send it to you and cascade it to all the other people. As far as I know I have sent everything to you."

We recommend the registered manager informs us immediately of any notifiable incidents and enhances their knowledge of which incidents are notifiable to the Care Quality Commission.

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.