Mrs Patricia Barrs and Mrs Regina Barrs

Alton House

Inspection report

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Date of inspection visit:
07 January 2020

Date of publication:
02 March 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Alton House is a care home, providing accommodation and support for up to 23 older adults including people who may have a diagnosis of dementia. At the time we inspected, there were 15 people living at the service.

People's experience of using this service and what we found
Risk assessments and the management of medicines were inadequate and did not support staff to ensure people received safe care. People told us they felt safe; however, the systems in place did not always protect people from abuse and harm.

Staff did not receive an adequate induction or relevant, up to date training to ensure they could provide effective care. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems did not support this practice. We found the service did not always act in accordance with the requirements of the MCA. The service did not always work well with other health and social care professionals and people's mealtime experience was not entirely positive.

A recommendation was made to ensure the service worked more closely with other health and social care professionals. We also recommended the service review people's experience at mealtimes.

People were not always treated in a kind and dignified manner. The service lacked a consistent approach to people being involved in the care and support they received.

We recommended the service provide care and support that ensures people are treated with dignity and respect. We have made a recommendation about involving people in decisions about their care

Care plans remained inconsistent and did not always guide staff to provide person-centred care. People were at risk of social isolation and did not engage in community activities. The service did not produce care related documents in a format that people receiving care could understand.

The quality assurance systems were inadequate as they had not identified the shortfalls we found during our inspection and did not ensure people were always kept safe. We found the service failed to demonstrate they were providing care and support that was safe, caring, effective or responsive. This put people at continued risk of harm.

There were enough staff to meet people's needs, and staff had been recruited in a safe manner. The service was clean, well maintained and managed infection control well. Lessons were learnt from accidents and incidents to keep people safe in the future.

The home had been designed and adapted with people's needs in mind. People were assessed prior to moving into the home and supported to settle and feel welcome. Staff told us they felt supported by their managers and received regular supervision. People's independence was encouraged, and the service promoted a culture and equality and diversity. The systems in place to manage complaints and end-of life care were sufficient.

Rating at last inspection
At the last inspection the service was rated Requires Improvement (Published 25 September 2019) and there were five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated 'Inadequate' in 'Safe' and remained in Special Measures.
This service has been in Special Measures since 15 October 2018.
During this inspection the provider did not demonstrate that improvements have been made. The service is rated as inadequate overall and in the Safe and Well-Led key questions. Therefore, this service remains in Special Measures.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of some regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alton House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, need for consent, person-centred care and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Alton House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one Inspector and one Expert by Experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was 'older people'. There was also an on-call pharmacist to support with medicines.

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

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

Notice of inspection
This inspection was unannounced and took place on 07 January 2020.

What we did before the inspection
Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require

providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with seven people using the service, and four relatives. We also spoke with 10 members of staff including the two registered managers.

It was not always possible to speak to everyone and ask direct questions about the service they received because of people's cognitive impairments. However, people could express how they felt about where they were, the care they received and the staff who supported them through non-verbal communication. We observed interactions between staff and all the people using the service as we wanted to see if the service communicated and supported people in a way that had a positive effect on their wellbeing.

We reviewed six people's personal care records, one staff record, staff rotas, medicine administration records and other records relating to the management of the service such as health and safety records and training records.

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

Assessing risk, safety monitoring and management
At our last inspection on 21 and 22 May 2019 the provider had failed to assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found enough improvement had not been made and the provider was still in breach of Regulation 12.

- People's risk assessments did not identify specific risks, and these were not reviewed on a regular basis to ensure they reflected people's up to date needs, which placed people at risk of harm.
- For example, one person's dependency assessment showed they began being fed by syringe on 3 June 2019 and continued to be fed by syringe until 14 July 2019. Following this date, no further notes were made about how this person was fed. Then on a different risk assessment we found that on the 9 August 2019 a staff member had recorded this person, "Is no longer on a food and fluid chart as appetite has increased." There were no records to confirm why this person was ever assessed as needing to be fed using a syringe, how this was being reviewed and whether this had ended or was ongoing. Furthermore, the food and fluid charts in place did not record exact intake of food and liquid. Staff told us this person was fed by a syringe to help them gain weight, but they were unclear what this person's weight was, if a health and social care professional had been involved and they had not received training. This person was at risk of being fed improperly, and this could result in dehydration, malnourishment or choking.
- We found for one person, many parts of their care file had not been updated in 14-15 months. Specifically, risk assessments for 'sight hearing and communication', 'personal care' and 'skin' had not been updated since November 2018. Therefore, staff would be unaware of whether this person's needs had changed over time, of what risks were associated with this person's conditions. These risk assessments did not include plans for managing the risk and therefore staff would not know how to mitigate associated risks.
- One person had requested their bedroom be locked from the outside while they were inside. However, there was no risk assessment in place to manage potential risk associated with this person having their door locked from the outside. For example, in the event of an emergency including a fire or if this person needed support, it was not clear how this risk was mitigated.

Risk assessments were inadequate and did not guide staff to know how to provide safe care and treatment. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection on 21 and 22 May 2019 the provider had failed to ensure the systems in place managed medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) 2014. At this inspection we found sufficient improvement had not been made and the provider was still in breach of Regulation 12.

● Medicines were not being managed safely; the systems in place to ensure the service understood people's support needs in relation to their medicines was inadequate.
● We found that medicines stored in the fridge were not always monitored according to the manufacturer's recommendations. Furthermore, covert medicines were not properly managed, and people were not receiving their medicines in line with the guidance from the prescriber. This meant that people were at risk of receiving medicines which were no longer functional.
● Care plans did not contain the necessary information about prescribed medicines and about people receiving 'when required' (PRN) medicines. Within care plans it was not always clear why people were prescribed these medicines, how they supported people to keep well, how they were affected by their medicines or how staff should support them with their medicines.
● For example, we saw one-person prescribed a spray to relieve the symptoms of angina. The spray was in the medicines trolley, but we did not see any PRN protocol to support staff to assess when this might be needed. This means staff could miss an important indicator in relation to people's support needs and relevant medicines; therefore, people may receive PRN medicines inconsistently and may be in pain.
● Some staff members were not competency assessed and had not received training to handle medicines. Records confirmed that four staff members had not completed medicines training and eight staff members had not had their competency to administer medicines assessed. As these staff members were administering medicines, there was therefore a risk people would not receive their medicines in a safe way.

Medicines were not being managed in a safe way and people were not protected from potential harm. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, we found that medicines were stored securely, including controlled drugs. We saw evidence that people who were prescribed insulin had a risk assessment in place including the use of emergency medicines. This guidance had been provided by a district nurse.
● Staff we spoke to told us they felt comfortable managing medicines and said they had now started working more closely as a team and with other professionals to manage medicines well.

Systems and processes to safeguard people from the risk of abuse
● The service had failed to ensure that there were established systems and processes in place to prevent people being at risk of abuse. We found the culture of the service disregarded the needs of people.
● Where people had been prescribed paracetamol, in quantities of up to 100 tablets per box, 200 of these tablets had been re-labelled and set aside for staff to take. Boxes of 100 paracetamols are prescription only medicine and can only be supplied by a pharmacist against a prescription for individual people. We were unable to identify which people had been prescribed these medicines the labels had been removed. The registered managers confirmed they were using people's medicines for staff use.
● This indicates financial abuse as people had their property stolen, misused and they had been defrauded. There was a potential risk therefore, that people's needs may not have been able to be met in relation to their pain relief and their medicine administration records and prescription requests may be inaccurate in terms of how much paracetamol they required on an ongoing basis.
● We spoke to the registered managers about our concerns and they advised they would stop using people's medicines with immediate effect. The CQC raised a safeguarding alert to the local authority.

Systems and processes do not ensure people are protected from potential abuse. This demonstrated a

breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, people we spoke to, and their relatives confirmed they felt safe living at the service.
● Staff told us, and records confirmed that staff were up to date with their safeguarding training and they understood the right processes to take if they suspected a person was at risk of harm. With regards to the breach discussed above, staff would not necessarily know this was a form of abuse.

Staffing and recruitment
At our last inspection on 21 and 22 May 2019 the provider had failed to ensure recruitment procedures were robust and the service could not be sure they were recruiting enough staff in a manner that ensured they were safe and suitable to provide care and support to people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had been made in this area and the provider was no longer in breach of Regulation 18 for staffing levels.

● There were enough staff to meet people's needs. We observed staff having time to spend with people in between tasks and they did not appear rushed. Staff we spoke to felt there were enough staff and the registered managers advised they were in the process of recruiting a full staffing team; in the meantime, they had a small number of agency workers who had worked at the service for a long time and knew people and their support needs well. This meant people received consistent care and support and staff understood people's needs. Rotas confirmed staffing levels were sufficient.
● Safer recruitment practices were followed. Pre-employment checks such as Disclosure and Barring Service (DBS) checks, references and proof of identity had been carried out as part of the recruitment process.

Preventing and controlling infection
At our last inspection on 21 and 22 May 2019 the provider had failed to ensure people were protected from the risk of infection. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvement had been made and the provider was no longer in breach of Regulation 15.

● The service had an infection control policy and observations confirmed staff were taking appropriate measures to protect people from cross infection. We observed staff wear appropriate personal protective equipment where necessary, including gloves and aprons. The home appeared clean and there was a clear system in place for staff to manage soiled laundry. There was hand gel available throughout the home.
● Relatives confirmed they had no concerns around the cleanliness of the home. One relative said, "Everything is clean and tidy." Another relative confirmed, "There are no smells."
● We found that all food in the kitchen had been labelled appropriately with its opening date, to ensure people did not consume food that is out of date or no longer safe to eat.

Learning lessons when things go wrong
At our last inspection on 21 and 22 May 2019 the provider had failed to assess and analyse accidents and incidents to ensure people were safe. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found sufficient improvement had been made in this area and the provider was no longer in breach of Regulation 12 for lessons learnt.

● Accidents and incidents were recorded, and any relevant action taken to ensure people were safe. Staff completed detailed forms when incidents or accidents occurred. This meant patterns or trends could be

identified and it meant the registered managers could ensure all appropriate actions had been taken.
● Records confirmed when a specific incident occurred, observations were put in place to more closely monitor people and encouraged staff to look for signs of ill health.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At our last inspection on 21 and 22 May 2019 the provider had failed to provide training to ensure staff were suitably qualified, competent, skilled and experienced to make sure they can meet people's care and treatment needs. We also found that the induction process in place for all staff was not relevant to the service and role they were undertaking. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found sufficient improvement had not been made and the provider was still in breach of Regulation 18 related to training and induction.

● We found there was still no relevant induction process in place for all staff. We were told by the registered managers that as no new members of staff had been recruited since the last inspection there had been no need to update the induction process. However, we were told, and records confirmed that one new member of staff had started working since the last inspection, and due to ongoing recruitment, the service was using agency staff to support the running of the service. There was no evidence that this new member of staff had received an induction to the service, and the service did not have an induction system in place should they recruit new permanent members off staff.
● We reviewed new guidance that had been put in place to advise what training staff should complete and how often training should be done. There was also a training matrix which indicated what training staff had or had not completed and when training was due. We found that despite being in place, these quality assurance measures were not effective. Records did not confirm that all staff were up to date with necessary training to enable them to provide good care to service users.
● We found the training matrix provided did not correlate with the list of staff members working at the service; one staff member was missing.
● The training matrix showed that staff had not completed dementia training since 2017, but the quality assurance spreadsheet said it had been completed in June 2019. As the matrix had been updated in July 2019 it was not clear why the dementia training was not reflected on this. Furthermore, records showed that End of Life training was due annually, but it had not been completed since November 2018. In addition, the training matrix showed that Duty of Candour training had last been done in May 2018, but the quality assurance document did not provide guidance about how often this is due. The registered managers confirmed this has not been reviewed.
● The registered managers were not able to confirm what had been completed. We could not be sure that staff had been supported to undertake training, learning and development to enable them to do their role.
● There was also no evidence of certain specialist training having been completed including for diabetes, syringe feeding and skin care. Therefore, we cannot be assured that staff knew how to provide care for

people that was safe and in line with their support needs.

The service had failed to ensure staff were suitably qualified, competent, skilled or experienced to provide safe care and support to people. This demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, we saw records to confirm, and staff told us they had completed other specialist training including how to support people living with dementia and Parkinson's.
● Supervisions and appraisals had been completed in line with the service procedures. This showed some systems had improved in the service to ensure staff were provided with the appropriate skills to support people in an effective manner.

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.

At our last inspection on 21 and 22 May 2019 the provider had had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice to support people who lack mental capacity to make an informed decision or give consent. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found sufficient improvement had not been made and the provider was still in breach of Regulation 11.

● There were no records to show that discussions about consent were held in a way that met people's communication needs. For example, one person's first language is not English but records about their care had not been provided in this language.
● Where the registered manager had assumed people were lacking mental capacity to give consent, the service had not acted in accordance with the requirements of the Mental Capacity Act 2005 and completed appropriate or relevant mental capacity assessments or best interest meetings. This meant it was not always clear what the service was doing to ensure people were okay with the care and support they were receiving and how people were receiving support in a way that best met their needs.

The service had failed to implement systems and processes effectively to ensure care and treatment is provided in line with the Mental Capacity Act 2005. This demonstrates a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a DoLs matrix in place, but it could not evidence that all DoLS had been applied for in line with best practice and it was not clear when it had been updated.
● We noted that it listed six people who were no longer at the service and did not include four people who had recently moved into the service. This document also showed that for six people their DoLS had expired

in 2019 and a renewal application had not been sent.
● This means for a period of over four months, six people had been deprived of their liberty unlawfully. The Registered Managers told us they had not had time to apply for the DoLS or review the matrix this since the last inspection.

The service had failed to protect people from abuse and improper treatment as they had been deprived of their liberty unlawfully. This demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, we observed staff knocking on people's doors and introducing themselves before going inside. Staff confirmed they understood how to gain consent from people with various communication and support needs. Records confirmed staff were up to date with MCA and DoLS training.

Supporting people to eat and drink enough to maintain a balanced diet
● People and their relatives were positive about the food and confirmed people had a choice of meals. One person told us, "They ask you what you want to eat." A relative confirmed, "The food's beautiful."
● Staff, including the chef, knew who needed support to eat and what people liked. Records in the kitchen regarding people's allergies, dietary needs, preferences and how food should be provided were accurate and up to date.
● Records showed the menu options included a variety of vegetables, meat and fish. People were given a choice of drink, and condiments were available. This demonstrated people were supported to have balanced and enjoyable diet and to stay healthy and well.
● However, our observations confirmed lunchtime experiences were not entirely positive. People were provided with paper napkins, but no table cloths; the music was faulty and kept skipping and people also had two televisions on at the same time. We found that there was no supervision in the dining area whilst people were eating, and at one point a person got up to retrieve a walking frame for another person. We also found the picture menu board was out of date, and incorrect. Furthermore, there was a long wait for dessert to arrive and people's main courses were not cleared when dessert was served.

We recommend the service considers people's preferences and needs at mealtimes to ensure the experience was positive and supportive.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People and their relatives told us the service worked well with other professionals to ensure people received care and support to keep them safe and well. One relative said, "They have been first class to [person] and to me. On two occasions [person] needed medical attention and they arranged it. I couldn't fault them." Another relative confirmed, "[Person] went to hospital, I find [staff are] really helpful people, nice people, and really, nothing is too much trouble."
● Records confirmed that on some occasions, people were being supported to receive care from other health and social care professionals, including the GP and occupational therapists. However, findings from the inspection show that in some circumstances the service wasn't always working well with other health and social care professionals. For example, with regards to people's skin, syringe feeding, specialist training and the local authority for the management of DoLS.

We recommend the service ensures they work more closely with health and social care professionals to ensure people receive safe and effective care and support.

Adapting service, design, decoration to meet people's needs
At our last inspection on 21 and 22 May 2019 the provider had failed to ensure the premises where care and treatment is being delivered is suitable for the intended purpose and maintained. This was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found enough improvement had been made and the provider was no longer in breach of Regulation 15.

● We found the décor and space was more dementia friendly; the signs around the home to direct people to the toilet, their bedrooms and fire exits were in place and clearer.
● The home appeared to have had a deep clean and so the flooring, furniture and walls made the service appear more welcoming and comfortable.
● The garden was in good condition; where appropriate sheds and fences to unsafe areas were locked shut and garden furniture was out for people, if they wished to sit outside.
● People's bedrooms had photographs of loved ones in and other items of their choice and there were more photographs up on the walls to show people participating in activities. One relative confirmed, "It's beautiful here. I can't complain about anything."
● All relevant health and safety checks were carried out to help ensure the premises and equipment used were safe. These included fire safety checks, and the gas and electrics within the building to make sure they were safe and in good working order.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service completed pre-admission assessments to identify people's support needs and determine if they can support people effectively. These pre-admission assessments looked at people's mobility, preferences around care and likes, their religion and relationships, and dislikes around food and activities. The service had a statement of purpose in place that told people and relatives about the process of moving in to the home, to make people feel more settled and comfortable.
● One relative said, "We got very good support on admission. I wouldn't want [person] anywhere else. [Person's] health is better, [person is] more content and happier and that's down to the home." This showed that the service was assessing people's needs to ensure they could deliver effective care and support.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Mostly, we found that people were treated with respect and their privacy was considered. One person confirmed, "I love it here. They care for you. They look after you. They're brilliant," and told us that they felt their dignity was respected as staff would draw the bedroom curtains when giving personal care. Observations confirmed most people were relaxed in the company of staff, and staff spoke about people in a respectful manner and had confidential conversations in a private space.
- We saw one person supported to maintain their independence; the service had arranged for this person to have a befriender who supported them with accessing technology, purchasing new clothes and attending appointments or other community activities. This person, with the help of the befriender and staff are now able to stand on their own to transfer which enables them to feel more independent.
- However, on some occasions we observed staff spoke to people in an abrupt and short manner when supporting them with moving and handling. This could be quite intimidating for people, especially where they have communication and sensory related support needs and may not be able to hear and see exactly what is happening. Another person was observed to be eating their napkin and had food down their front for some time before a member of staff stepped in to protect this person's dignity.

We recommend the service ensures they provide care and support that is considerate of individual support needs to ensure people are treated with dignity and respect.

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

- Relatives confirmed they were involved in reviewing their loved one's care, particularly with regards to people's preferences around daily routine and care and people's health. One relative said, "We get regular updates about [person]." Another relative told us, "If [person] needs anything I always get a phone call."
- However, we did not see evidence of people being supported to make decisions about their care, it was not clear where people lacked capacity to make decisions. We did not see any evidence of meetings being held where people had an opportunity to express their views.

We recommend the service ensures they have systems in place to support people to express their views about the care they receive.

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

- The service aimed to meet people's needs in relation to equality and diversity and care plans covered equality and diversity characteristics. The registered manager told us that there were no people in the home

now who practiced a specific religion, but if they did they would arrange for this need to be met.

● The registered manager told us none of the people using the service at the time of inspection identified as being lesbian, gay, bisexual or transgender. But they said if anyone did, they would seek to meet any related needs. One person confirmed, "They'll do anything for you."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant 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; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

At our last inspection on 21 and 22 May 2019 we recommended the provider seeks guidance from specialists to explore suitable activities for people living with dementia and other conditions, to ensure their wellbeing was maximised. At this inspection, the registered managers told us they had not sought specialist advice.

- Feedback about activities for people was mixed. During our inspection, we observed people sitting in the same position for long periods of time without any engagement or interaction. There was an activity timetable that was not followed.
- We found that at times, the televisions were showing inappropriate and potentially distressing shows. We found that the music playing was not necessarily tailored to evoke memories for people living at the service.
- One person told us, "It's very quiet compared to what I'm used to. [I am used to] going out dancing and mixing with the crowd, [now I am] just sitting here." Another person confirmed, "I [would] like to go out sometimes [but] they never go out." One relative said, "Not often when we go in are they doing anything."
- However, we saw a photograph board and records to confirmed that some activities had taken place including festive celebrations, and pet therapy.
- One relative told us someone comes in, "Once a week to do exercises." Another relative said, "They prefer people to be 'up' [out of bed] so they got a recliner chair [for person] so [they] could be in the sitting room in the day. It was lovely at Christmas for everyone and the relatives."
- Care plans were in place which discussed people's needs and preferences, associated with personal care, activities, medicines, sleeping and eating and drinking. However, they did not always set out for staff how to meet these needs.
- For example, one person's care plan about their medical diagnosis said staff were to, "Check for signs and symptoms, showing change of colour." However, there were no specific details of what the signs and symptoms are, or what to do if changes are observed. A second person's care plan looked at care preferences and identified this person was at risk of falling if unattended and should have, "Regular checks at night." However, there was no further guidance about how often these checks should be and daily records did not confirm these checks occurred.
- Care plans were not subject to regular reviews which meant they were not able to reflect people's needs as they changed over time. Some people's care plans had not been updated since November 2018. This showed the service had not maintained up to date care plans to ensure care is person-centred.

The service had failed to ensure people using the service received care or treatment that is personalised specifically for them. This demonstrated a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs; Improving care quality in response to complaints or concerns

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.

● At our last inspection on 21 and 22 May 2019 we found there was no easy read version of a complaints form available for people to access. This meant people who may have wanted to make a complaint or raise a concern about the service would not know how to and therefore not feel safe or supported. At this inspection, we found this had been implemented. We also saw a feedback box was available at reception for people, relatives or other visitors to use.
● People and relatives we spoke with did not wish to raise any complaints. One person said, "I can't complain about anything." A complaints policy was in place. There had been no complaints received since the last inspection.
● However, we did not see evidence of people being supported to make decisions about their care and their care plans had not been produced in a way that would make it easy or accessible to read for people with various communication and sensory related support needs.

We recommend the service ensures they have systems in place to support people to express their views about the care they receive.

End of life care and support
● We looked at individual care plans for people at end of life and found records in place for the 'last days of life'; one person's care plan discussed that they would like a priest present at the time of their death. Relatives confirmed they had good end of life discussions with the service.
● The registered manager showed us a matrix that was in place to monitor people's health monthly; people who were assessed as near end of life were monitored more closely so the appropriate care and support could be provided.
● There was an end of life policy in place that had been developed with the relevant professionals. Records confirmed all staff were up to date with end of life training. This showed the service was working well to ensure end of life care and support for people kept them safe and met their preferences.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection on 21 and 22 May 2019 the provider had failed to ensure there were effective governance systems and processes in place to assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found sufficient improvement had not been made in each of these areas and the provider was still in breach of Regulation 17.

● The registered managers and provider did not have a robust system in place to oversee the running of the service and they had not identified the concerns we found during our inspection.
● Specifically, risk assessments continued to be inadequate and medicines were not being managed effectively. Safeguarding procedures were not robust; new members of staff had not received an induction into the service and not all relevant training was up to date. The service was still not working within the principles of the MCA; there was limited evidence of multi-agency working and care was not delivered in a person-centred way.
● We reviewed the quality assurance systems, and specifically the audits that were in place to ensure people's records were up to date; this was blank. We were advised by the registered managers this had not been kept up to date and was not currently being used. This meant there was no way of knowing when relevant reviews of people's records were required and as a result it was difficult to know if people's care was safe, effective and person-centred.

This shows that the service did not maintain accurate, complete and contemporaneous records relating to the care and treatment of people living at the service. This demonstrated a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, people, staff and relatives felt there had been positive changes to the running of service. One relative said, "I'm very pleased with the care. It's improved over the last year." Another relative told us they see "the manager" around the home whenever they visit and would recommend the service to other people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics
● The service sought feedback through surveys and meetings with relatives and staff. One relative told us the monthly meetings were worthwhile. Another relative said, "There's a monthly meeting. You can go in the office anytime and talk to the [staff] in there."
● We reviewed surveys from relatives and found that feedback was mostly positive. Comments included, "I find all the staff friendly and helpful," "Cleanliness is fine," and "The care [person] has received has been excellent." The registered managers told us they were working to increase the return of feedback forms and were trying to get more from health and social care professionals.
● Staff told us, and records confirmed they attended monthly team meetings. One staff member said, "We get support whenever we need."
● However, we did not see any evidence of people being involved in their care. This showed that the service was not always consistent in being inclusive to ensure people felt included in their care package.

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
● The statement of purpose was up to date and reflected the running and set up of the service.
● The service was aware of, and adhered to, their legal responsibilities regarding notifications. They had informed the Care Quality Commission of any significant incidents in a timely manner.
● Unannounced spot checks were done by the registered managers; there had been nine checks in a period of six months. These looked at infection control; staff tasks and people's wellbeing.
● Accidents and incidents were reviewed to see what lessons could be learned from them. This helped reduce the risk of similar incidents occurring.

Continuous learning and improving care; Working in partnership with others
● The registered managers told us they worked well with other agencies to develop and share good practice and attended the providers forum run by the local authority. They said, "They are helpful. We can meet other providers, discuss challenges. We meet other experts and managers."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The providers were not doing all that was reasonably practicable to make sure people who use the service receive person-centred care that meets their needs and reflects their personal preferences.