Autism TASCC Services Limited

Collinson Court

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We inspected this service on 25 and 26 June 2015. This was an unannounced inspection. Our last inspection took place on 18 October 2013 where we found that the provider was meeting the Regulations that we inspected them against.

The service was registered to provide accommodation and personal care for up to 12 people. People who use the service have Autism and behaviours that challenge.

Behaviours that challenge are behaviours that place a person or other people at risk of harm or reduced quality of life. At the time of our inspection 12 people were using the service.

The service had a registered manager. However, they had been absent from the service since January 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A temporary manager who was registered to manage another of the provider's service was managing the service at the time of our inspection.

During this inspection we identified a number of Regulatory breaches. You can see the action we have taken at the bottom of this summary.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. People were also not always protected from potential abuse and medicines were not always administered safely. This meant people were not always kept safe and their welfare and wellbeing was not consistently promoted.

Advice from health care professionals was not always followed which resulted in a number of safety incidents occurring. Lessons were not learnt after safety incidents, which meant the risk of further incidents was not reduced.

Staff did not always fulfil their responsibilities to keep people safe. This was because the staff were not effectively led and managed.

Staff did not recognise that they were at times physically restraining people in order to keep them safe. This meant that the required protocols to ensure such incidents were managed safely and effectively were not being followed.

We saw that most people had a high level of restrictions placed on them in an attempt to keep them safe. However, staff did not always identify, consider or review the restrictions they placed on people which meant people could not be assured that they were being lawfully restricted.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider. The provider did not always inform us of incidents that occurred at the service which meant we were not always aware of reportable incidents that had occurred.

There was limited evidence to show that people's care was based on best practice for people with autism and behaviours that challenged.

There were gaps in the staffs' knowledge and skills that meant some people's specialist needs were not met effectively. Staff and relatives were not always aware of the changes in management which led to some uncertainty.

People were not always supported to make decisions about their care and people were not always treated with dignity and respect. Independence was not consistently promoted and people sometimes experienced inconsistent care. This meant there was a risk that people could become confused which could result in an increase in anxiety and display of behaviours that challenged.

Staff did not always understand people's communication styles which meant there was a risk that people may not always be able to express their needs effectively.

People were enabled to access the community, but improvements were required to ensure the activities people participated in were meaningful and purposeful to them.

Most of the staff demonstrated that they valued the people who used the service and the manager and provider were aware of some of the shortfalls and were positive about improving people's care. When complaints were received the provider managed these in accordance with their complaints procedure.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed, and people were not protected from potential abuse.

Staff did not always fulfil their roles in keeping people safe and people's medicines were not always managed safely.

Is the service effective?

Inadequate 

The service was not effective. The staff did not always identify, consider or review the restrictions they placed on people which meant people could not be assured that they were being lawfully restricted.

People's health needs were not always assessed and monitored to promote their wellbeing. People's nutritional risks and needs were not assessed and met.

Communication with health and social care professionals was not always effective. Staff did not always have the knowledge and skills required to meet people's needs.

Is the service caring?

Requires improvement 

The service was not consistently caring. People did not always receive care and support in a manner that promoted their dignity and independence.

Age appropriate language was not always used which meant people were not always treated with respect.

People were not always enabled to make choices about their care.

Is the service responsive?

Requires improvement 

The service was not consistently responsive. People did not always receive consistent care that met their needs and preferences.

Staff were not always aware of people's communication methods which meant some people may not have been able to make their needs known.

There was a complaints policy in place and complaints were managed appropriately, but not all relatives were aware of whom to report a concern to.

Is the service well-led?

Inadequate 

The service was not well-led. Effective systems were not in place to assess, monitor and improve the quality of care. This meant that some areas of poor care were not identified and rectified by the provider.

Staff were not always aware of their responsibilities and requested more effective organisation of their shifts.

Summary of findings

There was limited evidence to show that care was based on best practice guidance for people with Autism.	

Collinson Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 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 Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 26 April 2015 and was unannounced. Our inspection team consisted of two inspectors and a specialist advisor whose specialism was Autism and the management of the behaviours that people with Autism could display.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

The local authority had recently placed the service under a large scale investigation. This was due to the number of safety incidents that had occurred at the service.

We spoke with 10 people who used the service, but due to people's communication difficulties they were not all able to tell us about their care experiences. We also spoke with three relatives, ten members of care staff, the temporary manager, another manager who worked for the provider and one of the provider's positive behavioural support specialists. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at seven people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included quality audits, staff rotas and training records.

Following our inspection we made two referrals to the local authority's safeguarding team. We did this because of significant concerns we identified with these people's care.

Inadequate

Is the service safe?

Our findings

People who used and visited the service told us they did not always feel safe. When we asked one person if they felt safe they said, "No, I don't like [another person who used the service]". Following our inspection, the local authority made us aware that this person had been assaulted by the person they did not like. We observed one person who used the service flinch when another person who used the service came near to them. The person could not confirm that they were scared of the other person, but incident records showed that the other person had frequently been involved in incidents of assault towards people and staff. A visiting relative told us that they did not always feel safe because they had previously been assaulted by a person who used the service.

Risks to people's health and welfare were not effectively managed to protect them and others from harm. Care records showed and staff confirmed that some people's risks had not been assessed and planned for. For example, an incident resulting in two members of the public being 'pushed' had occurred during a visit to a local health centre because there was no plan in place to guide staff on how to manage the person's risk of distress during visits to the centre. The person had an appropriate support plan in place for visits to the dentist but a similar approach to risk assessment and management had not been considered or used for other heath related appointments.

We found that avoidable incidents occurred because staff did not follow the guidance contained in people's support plans. For example, one incident record showed that a staff member had been left alone with a person who required the support of two staff. The staff member had been 'charged at' by the person when they had been left alone with them. This incident occurred because the person did not have the level of support they required to keep them and the staff safe. One staff member told us they were frustrated by this incident. They said, "[The person who used the service] knows which staff are more vulnerable, staff should not be left in that position".

We saw that when incidents occurred, action was not taken to review and prevent further incidents from happening. For example, staff told us, records showed and we saw that one person frequently tried to climb an obstacle to access other areas of the service. Staff told us and records showed that the person had injured themselves on one occasion whilst attempting to climb. Action had not been taken to reduce this risk. One staff member told us, "[The person who used the service] will come a cropper one day" and, "It's simple really, we just need a taller gate but nothing's been done". Another staff member said, "I was told not to physically intervene with people. I just hope and pray they don't hurt themselves". We made the manager aware of this risk on the first day of our inspection and no changes were made to the person's risk assessment or support plan in response to this.

The above evidence demonstrates that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of potential abuse. We found that when suspected abuse had occurred the provider did not always take the action required to minimise the risk of further incidents. For example, when a staff member had been suspected of causing harm to a person who used the service, we saw that they remained working at the service with no effective safety measures in place to protect people from further incidents.

Effective systems were not in place to ensure suspected abuse or actual harm were consistently reported to the local authority in accordance with local safeguarding procedures. The agreed local safeguarding procedure requires that staff should immediately report safeguarding concerns and incidents to them so they can consider if any action is required to manage or minimise further incidents from occurring. We found that safety incidents were not always reported in a timely manner. For example, one safety incident was not shared with the local authority until two days after the incident. The incident was also not immediately shared with the person's social worker who visiting them during the afternoon following the incident. We found that one person had recently sustained bruising to their body following an incident. The manager had not been made aware of the bruising, so had not reported this to the local authority's safeguarding team. As soon as we made the manager aware of this incident, they did report it to the local authority.

Inadequate

Is the service safe?

The above evidence demonstrates that people were not consistently protected from potential abuse. This was a breach of Regulation 13 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to manage people's medicines. However they were not always effective. We identified a medicines error whilst reviewing people's medication administration records (MAR's). The error had occurred earlier in the day, but staff were not aware of the error until we reported it. After we reported it medical advice was sought. On the second day of the inspection the staff also made us aware of a second medicines error that had occurred. The second error occurred because the person administering the medicines signed the MAR's without checking that a person had taken their prescribed medicine. The person's unused medicine was later found after a significant period of time. This resulted in the person receiving their medicine much later than usual.

We saw that one person who was prescribed a medicine to help manage their anxiety 'as required' had recently received this medicine on a regular basis. There was no guidance available to guide staff on when to administer the different prescribed doses of the person's 'as required' medicine. There was a protocol in place that stated the medicine could be given when the person displayed high anxiety levels, but there was no reference to how much medicine should be given as the person was prescribed two different doses. We asked a staff member responsible for giving medicines how they knew how much medicine to give. They told us, "We use the higher dose first and we can administer more later if needed". When we looked at the MAR's for this person they showed that on most occasions staff started with the higher dose first. However on one occasion we saw that only the lower dose had been administered. This showed that the person had received their 'as required' medicine inconsistently and there was a lack of clear guidance for staff to follow.

The above evidence demonstrates that effective systems were not in place to ensure people received their medicines safely and consistently. This was also a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were enough staff available to meet people's needs and safe recruitment systems were in place. However, staff did not always fulfil their responsibilities to keep people who used and visited the service safe. For example, one person who required one to one support during the day time held one of the inspector's arms and led them to a garden area. The person kept hold of the inspector for a 15 minute period. During this time the person's allocated one to one staff member was not visible and they did not attempt to intervene to ensure the inspector was safe. We later found that the person responsible for this person's care was completing some cleaning tasks.

We saw other recent incidents that had occurred because staff were not fulfilling their responsibilities to provide people with the level of observation and support they required. For example, we saw that one incident occurred because the two staff who had been allocated to support a person as planned were not doing this. One staff member had left the area where the person was and another staff member was talking to a passing member of staff. This left the person unsupervised for long enough to climb over the gate in their garden.

The above evidence shows that staff did not always fulfil their responsibilities to keep people safe. This was also a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Is the service effective?

Our findings

The local authority and a relative had informed us that staff did not always act in accordance with the law when people could not make decisions for themselves about their health and welfare. Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests when they lack sufficient capacity to be able to do this for themselves. Staff told us about the basic principles of the Act and the DoLS, and we saw that mental capacity assessments and DoLS referrals were made. However, we saw that some restrictions placed on people were not included or considered in their DoLS applications/authorisations.

For example, one person's cupboards, wardrobes, kitchen and bathroom were kept locked until they needed to be accessed. Some of their light switches were also only accessible to the staff. Staff told us that these restrictions were placed on the person to keep them safe. However, with the exception of the kitchen none of the other restrictions listed had been care planned for or included in the person's DoLS application. The manager told us they were unsure why there were so many restrictions placed on the person and in relation to the restricted light switches they said, "I'm not sure why some of them are like that because some are and some are not". The same person was also restricted when they were transported in one of the service's vehicles. Staff told us that this was because of an incident that happened a number of years ago. There were no plans in place to review the person's need for this restriction and staff confirmed that the person had been using the vehicle without any problems for some time. Not identifying, considering and reviewing the restrictions placed on people meant that people could not be assured that they were being lawfully restricted.

All the staff we spoke with and the manager told us that physical restraint was not used at the service. However, we saw and care records showed that people were at times being physically restrained by the staff. For example, we observed two staff members prevent one person from climbing a gate in their garden by pulling them off it on three occasions. They said they did this to keep the person safe. No incident forms were submitted in relation to these three incidents and no reference to the physical restraint was recorded in the person's care records. This meant there was no written record of the techniques used so no analysis of the use of restraint could be completed to ensure staff acted appropriately and within the law. The Department of Health's Positive and Proactive Care: reducing the need for restrictive interventions 2014 states, 'Where unplanned or unintentional incidents of restrictive practice occur there should always be a recording and debrief to ensure learning and continuous safety improvements'. This showed that the service was not identifying, managing or monitoring incidents involving the physical restraint of people who used the service.

The above evidence shows that effective systems were not in place to ensure people were lawfully and safely restricted when this was required. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed that people's health needs were not consistently followed. One person's support plan showed their bowel movements required monitoring as constipation had been identified as trigger for their behaviours that challenged. Staff told us that this person's behaviours were escalating because they believed they may be constipated. The staff member showed us the person's bowel monitoring chart and said, "I'm not sure if [the person who used the service] is constipated or not because the chart hasn't been filled in right". We saw there were gaps on the chart which meant staff could not confirm if the person was or was not constipated.

We saw that people had access to health and social care professionals. However, communication about people's health and welfare were not always effectively communicated to relevant professionals. For example, one person's care records showed that when their doctor asked staff if any restraint had been used to manage the person's behaviours that challenged, staff had told them no restraint was used at the service. However we saw that an incident had occurred shortly before the meeting that resulted in the person being physically restrained by two members of staff. This meant the person's doctor was not made aware of the intensity of the person's behaviours that challenged.

Advice from health and social care professionals was not always followed. For example, during a health and welfare review a doctor had recommended that the permanent furniture in one person's living space was secured to the floor to reduce the risk of the person throwing their

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Is the service effective?

furniture and injuring themselves or others. We saw that this advice had not been followed and care records showed that on two occasions following the meeting with the doctor the person had thrown a chair at staff members.

Effective systems were not in place to assess and monitor people's risk of weight loss or weight gain. The manager confirmed that there were no nutritional risk assessments or monitoring tools in place. Care records showed that one person was gaining significant amounts of weight. This person had a support plan in place with the aim of promoting a healthy diet and weight loss. This plan had been recently reviewed by staff as being effective and no changes to the plan were required. We saw that a healthy diet was not always promoted. For example we saw that during a seven day period this person did not eat a healthy diet. The person was also gaining weight. This showed that the person's support plan for weight loss and healthy eating was not effective.

The above evidence demonstrates that effective systems were not in place to ensure people's health and welfare needs were effectively monitored, communicated and evaluated to promote safety and wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some staff did not have the knowledge or skills to work effectively in their roles. For example, one staff member had poor communication skills which meant they could not answer our questions about people's care or follow the instructions given to them by the manager. Staff told us and records showed that they completed training to help them carry out their roles, but we saw that this training was not always effective. For example, we saw that protective equipment such as aprons were not always used to reduce the risk of cross contamination and hand washing procedures were not always followed when preparing food.

Staff told us that they met regularly with the manager to discuss their development needs. However, there was no evidence to show that these meetings were used to discuss performance issues or safety concerns. The manager confirmed that despite the number of incidents that were related to staff not fulfilling their roles, no staff member's performance was being managed to improve their effectiveness.

The above evidence demonstrates that effective systems were not in place to ensure staff had the knowledge and skills required to work effectively at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were unable to identify if people could consistently choose the foods they ate and we found that staff were not always aware of people's food preferences. We asked staff if people chose the foods they ate. All the staff we spoke with told us that meals were planned a week in advance, but none of the staff could tell us how people were involved in this process. We carried out a meal time observation in one area of the service where all four people were served the same meal. One person did not eat one of the food types they were served and when we asked staff if they did not like that specific food they told us they were unsure. This person was not offered an alternative food option which meant the main carbohydrate part of their meal was missed.

Requires improvement

Is the service caring?

Our findings

We saw that people were not always treated with dignity and respect. We observed a staff member attempt to adjust one person's underwear in a communal area in the presence of other people. The manager observed this and prompted the member of staff to move to a private area to assist the person.

We observed one staff member ignore one person's request for a drink. The person stood by the locked kitchen door holding their cup repeatedly stating, 'tea'. The person also attempted to open the door by moving the door handle on multiple occasions. After a five minute period a staff member came out of the locked kitchen and walked past the person. We asked the staff member if they heard the person asking for tea and trying the door handle, but they did not answer our question.

We found that staff did not always communicate with people in an age appropriate manner. One staff member told us they had a good relationship with one of the people who used the service and they described how they interacted with them. They said, "I always ask them if they've been a good boy". The person they were referring to was an adult not a child. Care records showed that staff used language such as, 'played in the garden' and 'behaving well' when they recorded one person's daily routines. This language was not appropriate to describe the activities of an adult.

We found that independence was not consistently promoted. People were not always encouraged to participate in activities of daily living, such as making drinks, meal preparation and cleaning tasks. For example, we saw one person ask for a drink. The manager told a staff member to let the person make their own drink as they were able to do this with close supervision and prompts, but the staff member ignored this request and made the drink for the person. We asked the staff member why they had not enabled the person to make their own drink, but they did not answer us.

Although people could not tell us that they were involved in making decisions about their care. We saw that some staff offered people verbal choices about how they spent their time. For example we saw people were asked if they wanted to go for a walk in the local community. One person chose not to and their decision not to participate in this activity was respected. Improvements were needed to ensure a consistent approach to offering choices was used as some staff did not always do this. For example, one person with the support of a member of staff chose to wear a coat for their walk, but another staff member took the coat off the person and replaced it with a cardigan without discussing the reason for this.

People's relatives told us they felt the staff were kind and considerate. One relative said, "The staff are very nice", another relative said, "[Their relative] gets on with the staff okay". We observed some positive interactions between staff and the people who used the service. For example, we saw that when people became distressed staff offered reassurance and comfort.

Staff were mostly able to tell us about people's individual likes and dislikes. We saw that staff used this knowledge to talk to people. For example, we saw a staff member talk to one person about cars because this was one of their interests. The person indicated they enjoyed the conversation by smiling and nodding their head.

The staff were aware of people's right to privacy and we saw that people were enabled to have periods of 'private time' at their request.

Through talking with staff, it was evident that the majority of staff valued working with the people who used the service. One staff member described a person who used the service as, "Beautiful with lovely charisma". Another staff member said, "[A person who used the service] is great to work with, they are so loving and they have a great sense of humour".

Requires improvement

Is the service responsive?

Our findings

People did not always receive consistent care that met their needs. For example, one person had a plan in place to guide staff on how to manage one of their behaviours that challenged. Staff gave us inconsistent accounts of how they managed this person's particular behaviour which meant the person was receiving inconsistent care. In a person with autism inconsistent care could result in confusion and may trigger behaviours that challenge.

Some people were unable to verbally communicate their needs. We found that staff were not always aware of people's individual communication styles. Staff told us one person was able to show them what they wanted by using Makaton (a communication method using signs and symbols) or by leading staff to the area that they wanted to go to. Two staff members told us they regularly worked with this person but they could not use Makaton as they had not been trained in this. None of the staff told us that the person was able to use a pictorial based communication method known as PECS (Pictorial Exchange Communications Systems) which the person's care records stated they were able to use. This meant there was a risk the person would not be able to effectively communicate their needs because staff were not aware of or did not understand their communication style.

Some people were unable to actively participate in all elements of care planning. Relatives gave us mixed views about their involvement in the planning of care. One relative told us they were fully involved and had attended a recent care review meeting. The other relative told us despite asking to be involved in care planning and reviews they had not been involved to date. They said, "I asked the deputy manager some time ago if I could be involved and they did apologise saying they hadn't realised I wanted to be involved, but I still haven't been invited to talk about the care". The manager told us they would involve this relative in the person's care in the future.

We saw that people had care reviews with the staff, but we found that staff did not have the skills to work with people to set realistic and achievable goals. One person's review contained a goal that the manager agreed was unachievable and unrealistic. The person's care records contained no information around how the person could work towards the goal in the future. Staff confirmed no work was being made towards achieving the goal as it was not appropriate to work on.

We saw that people were given the opportunity and were enabled to access the community on a regular basis. We saw people going on day trips, shopping, swimming and walking. However, we saw that some people went out in groups when this may not always have been in their best interests. We saw one person who was reluctant to get on the service's minibus with some other people who used the service. This person had arrangements in place to ensure two staff supported them in the community. We asked staff if this person liked the company of others. One staff member said, "[The person who used the service] likes to get all the attention from the staff". The person couldn't tell us if their preference was to go out within a group or not, but the behaviours we observed suggested they did not want to participate in the group activity. This meant we couldn't be assured that the person's individual preferences of how they spent their time were consistently met.

People who used the service were unable to tell us how they would complain about their care. There was a pictorial easy read version of the complaints policy in people's records, but we did not see that this was on display in any areas of the service. The formal complaints policy was in display in the reception area. Despite this, some relatives told us they were unsure how they would make a formal complaint. Two relatives told us they would speak with the deputy manager if they did have a concern. Neither relative was aware that they would be unable to speak with the deputy manager as they were currently not working at the service. This showed that some relatives were not kept up to date with temporary changes to the management team.

The provider had a complaints procedure in place and complaints from relatives who knew how to complain were under investigation in accordance with the provider's complaints policy and procedure.

Inadequate

Is the service well-led?

Our findings

Relatives told us they were not sure who was managing the service. One relative said, "There have been lots of staff changes, I'm not sure who is in charge at the moment". Staff also said they were unsure of the changes that were occurring at management level. One staff member said, "We don't know what's happening. Staff would be happier if we did". The registered manager had been absent from the service for over five months and the deputy manager had recently become absent. Because some of the relatives were not made aware of the management changes some were unsure of whom to approach in the event of a concern or complaint.

Effective systems were not in place to enable the provider to assess, monitor and improve the service. We saw that the provider visited the service to assess and monitor quality. However, we could not be assured that these visits were effective. Areas of concern that we had identified such as, responding to and analysing incidents to reduce people's risks and the unrecognised use of physical restraint had not been identified by the provider and were not included in their service improvement action plan. This showed the quality monitoring systems were not effective in enabling the provider to consistently identify and respond to safety concerns at the service.

Although the provider had an action plan in place, we found that this had not been effective in making the required improvements. For example, the provider had signed off that an action relating to the completion of DoLS referrals had been completed. We saw that the DoLS referrals had been made, but the quality and accuracy of these referrals had not been checked. We identified two DoLS referrals that did not cover all the restrictions that were placed on people.

Some of the actions identified in the provider's quality visits had not been incorporated into the service's overall action plan that the manager confirmed that they were working from. For example, in February the provider had identified that pictorial menus should be used and displayed to enable people to be involved in meal planning. These pictorial menus were still not in place and had not been incorporated onto the service's action plan.

Effective management and leadership systems were not in place. The manager told us that a change in culture at the service was needed to drive improvements. They said, "Some staff have been working against us". We asked if these cultural issues were being managed under supervision and performance management. They told us and we saw that they were not. For example, when incidents occurred because staff had not fulfilled their roles effectively, no action was taken to address any performance issues. This meant staff were not enabled to learn from their mistakes.

Staff told us they needed more direction to enable them to work effectively. One staff member said, "I would like it more organised so that we all know what we are doing". Another staff member said, "It can get confusing sometimes about who is doing what". The manager told us that it was the senior staff's responsibility to allocate staff to specific people and specific tasks. They also told us that some changes were needed to ensure the senior staff worked more effectively. They said, "The senior staff need an overhaul" and, "We are going to address this, but at the moment we are fire fighting". On the first day of our inspection two senior staff were on shift, but on the second day no senior staff were on shift. The manager told us they guided staff in the absence of a senior staff member. This meant that in these instances the manager was taken away from their other management responsibilities and the allocation of senior staff had not been managed appropriately to ensure a senior staff member was available on each shift.

There were no effective methods used to gain feedback from people who used and visited the service. The manager told us that two people had completed satisfaction surveys with staff, but these had not yet been analysed. One relative told us they were asked for verbal feedback about the care during a review meeting, but none of the relatives we spoke with told us they had been given the opportunity to provide written feedback about the care through a survey. One relative said they were less likely to give verbal feedback as they were, "Not much of a complainer", but they would be, "More than happy to fill in a form". This showed that consideration had not been given to ensure a variety of methods were used to gain feedback about the quality of care.

We saw that people's care records were not always kept secure which meant confidential information about people was not always safe and the records were not always accessible to people who needed to use them. We had

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Is the service well-led?

difficulties reviewing one person's care records as another person who used the service had attempted to destroy them. The manager told us they were not sure why the records were stored where they could be found by another person who used the service.

The manager told us that they had recognised that staff had not been empowered to work in people's best interests. They said, "Staff were not empowered, they were asking me for permission to take people out for a walk. Things have started to improved now and people are going out more now the staff know they have the permission to do this" and, "Activities have increased tenfold since I've been here". We saw that most people were increasingly participating in social and leisure based activities, but the manager agreed that improvements were needed to make activities more meaningful for people. They said, "There is a lack of meaningful activity, but we are planning on introducing this".

We saw limited evidence that people's care was based upon best practice guidance. For example, alternative non-verbal communication methods were not always accessible or consistently used and people had no visual activity schedules that they could use to create structure and routine and reduce uncertainty. We saw that the provider was slowly making progress in introducing a positive behaviour support (PBS) approach at the service. PBS is a recommended evidence based approach that is used to enable people to understand the cause of behaviours that challenge and it promotes positive methods to enable people to achieve what they want to achieve and improve quality of life. We saw that one person had a draft PBS plan in place, but this was yet to be used with the person.

The above evidence shows that the service was not well-led. Effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not fulfil the requirements of their registration with us. We had not been notified of multiple safeguarding incidents in a timely manner and we had received no notifications to inform us that some people had authorised DoLS in place. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager and provider were aware that significant improvements were required at the service. The manager said, "The service needs a lot of improvement" and, "The staff team haven't had the right management". Despite the manager being aware of the shortcomings in care, they remained optimistic about the potential to make improvements. They said, "There is such potential here because of the service users and the staff, the staff just need the rights tools and skills to do it".