Mrs S T Brown

The Paddocks - Braintree

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Paddocks is a small residential care home which provides accommodation and personal care for up to six adults with learning disabilities who require 24 hour support and care. The service comprises of a bungalow with a large garden area to the rear. At the time of the inspection there were six people living in the service.

Our inspection was unannounced and took place on 20 September and 3 October 2016. The service had a registered manager in post. 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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures 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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Some risks to people had been assessed but assessments were not personalised or detailed and had not been regularly reviewed. There was no system in place for reviewing risk assessments which meant that they did not always reflect people's current needs.

People received their medication on time. However, there were no systems in place to record the administration of homely remedies and topical creams were opened but not named or dated. One person had been receiving covert medication but no capacity assessment had been completed and there was no supportive information from the GP to support this decision. The provider did not carry out internal medication audits or assess staff competencies.

The premises were clean but the garden area was not well maintained or safe for people to use.

Staff were not supported to access training to maintain, develop and update their skills. Staff had not completed any mandatory or additional training for a number of years. One person required the use of a hoist however, staff had not completed annual refresher manual handling training to ensure that they were competent to meet the needs of this person.

Systems were in place to ensure that the appropriate recruitment checks had been carried out on staff before they were recruited into the service. However, new staff were not appropriately inducted into the service and staff did not receive regular supervision or annual appraisals.

Staffing levels were not always sufficient to meet the needs of the people living in the service. The provider did not have a systematic approach to determine the number of staff required to meet the needs of the people using the service and keep them safe at all times. One person living in the service required the assistance of two staff but at night time there was only one member of staff on duty. People's choice of activities were also restricted because there were not always enough staff available to support people's care needs and support people in the activity of their choosing.

Whilst care was provided in a way which was intended to keep people safe from harm, staff had not received recent training to recognise signs of potential abuse. This meant that they had a limited understanding of the Mental Capacity Act 2005 (MCA) and what actions they would need to take to ensure the home adhered to the MCA Code of Practice. No capacity assessments had been completed and no applications for Deprivation of Liberty Safeguards (DoLS) had been made to the Local Authority. Where decisions had been made on behalf of people the least restrictive option was not always chosen.

People's nutritional needs had been assessed and people were supported to have a varied and healthy diet. However, staff were not accurately monitoring and recording the food and fluid intake or weight of people who had been identified as at risk of weight loss.

Staff knew people well and we saw that they were caring and kind when supporting people. However, we found that people were not always supported to be as independent as possible and the way that staff spoke to people and the written language in care plans was not consistently respectful.

People were not involved in planning activities or how they spent their leisure time. There were only a limited range of meaningful activities organised for people to engage in both inside and outside of the service and there was no evidence that people were given the opportunity to give feedback or make decisions about their care and support. There was a complaints system in place but it needed updating and the service had not produced any guidance or information on making complaints in a suitable format for the people who lived at the service.

The service was not well led. The registered provider had not ensured that there was good governance of the service. There was no evidence that quality assurance systems were in place to assist in monitoring, assessing and reviewing the service. There was no service improvement plan and the provider did not link to any local networks to ensure they were updated on new information and legislation related to adult social care.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medication was not always well managed or stored safely.

People were not always kept safe and staff did not always treat them with dignity and respect.

There were not always sufficient staff on duty.

Is the service effective?

Inadequate

The service was not effective.

People were not cared for by staff that were well trained.

Staff had not received regular supervision and were not supported.

Staff, including the registered manager, did not have knowledge of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) and had not been provided with training. Assessment were not in place for those people who were unable to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

People were provided with care and support but this was not always tailored to their individual needs and preferences.

Staff understood people's care needs but people had not been involved in making decisions and planning their own care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive consistent, personalised care and support and had not routinely been involved in the planning and reviewing of their care.

People had not been empowered to make choices and were not routinely encouraged to be as independent as possible and have control of their lives.

Is the service well-led?

Inadequate

The service was not well-led.

Staff understood their role and but were not confident to question practice or report any concerns.

The service did not have effective quality assurance systems in place.

The provider did not have a clear oversight of the issues affecting the service and they did not demonstrate to us an understanding of the requirement to implement quality assurance processes.

The service did not have systems in place to gain the views of people who lived at the service or a formal system in place to help empower people and get them involved in the running of the service.

There was no service improvement plan in place and the service did not link to any local networks to ensure they were updated on new information and legislation related to adult social care.

The Paddocks - Braintree

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 is 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.

The inspection was unannounced and took place on the 20 September and 03 October 2016. The inspection was undertaken by one inspector on the first day and two inspectors on the second.

As part of our inspection we reviewed information we held about the service. This included notifications, which are events happening in the service that the provider is required to tell us about. We used this information to plan what we were going to focus on during our inspection.

During our inspection we spoke with the registered provider, the administrator and three members of the care staff. Two relatives and health care professional were spoken with for their views about the service and where possible their feedback has been added to the report.

Not everyone who used the service was able to communicate verbally with us. Due to this we observed interactions between people and staff, reviewed records and looked at other information which helped us to assess how their care needs were being met. We spent time observing care in the communal area and speaking with those people who were able to tell us what it was like to live at the service.

As part of the inspection we reviewed three people's care records, this included their care plans and risk assessments. We also looked at the files of six staff members.

We also looked at a sample of the service's policies, audits, staff rotas, complaint and compliment records, medication records, personal allowance accounts and training and support records.

Inadequate

Is the service safe?

Our findings

The service had a safeguarding policy in place, but this did not reflect information on the Local Authority's responsibilities or provide information on where safeguarding concerns can be referred to. The information available for safeguarding people required updating to include guidance and information to help staff protect people from potential harm and give them a better understanding on the process. Also, information had not been made available to people in an appropriate format to support them to understand what keeping safe means or to advise them of who they could speak with if they had any concerns about their well-being.

When looking at staff documentation this showed that only two staff working at the service had completed Safeguarding of Adults training and this was in 2005 and 2008. No further staff had attended any form of training on safeguarding vulnerable people, and refresher training had not been organised. When speaking with staff some were able to explain how they would recognise abuse and who they would report their suspicions to, but their knowledge was variable. One staff member stated they would 'speak with their manager,' but on further discussion it was clear that they were not aware of what other organisations they could report issues to if needed. They added, "It is a long while since I have done my training." The service had a whistle blowing procedure in place for staff to use and this provided information on who they could take any concerns to and what would happen with the information provided.

Some people living in the service had their monies managed by family members or Essex Legal Services. However, some concerns were raised in connection with the services costing's for the use of the mini bus. Records indicated that the total cost of journeys was calculated on the number of people on board the mini bus rather than on the distance travelled. We looked at the finance sheets for each person, however in most cases only a lump sum had been recorded with limited information available as to how this figure had been calculated or the purpose of the journey that had taken place. We discussed with the provider that a clearer system needed to be implemented to demonstrate how people's individual mileage expenditure had been calculated and to ensure that people were not placed at risk of financial abuse.

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

Some risks to people had been assessed but the assessments were not detailed and had not been regularly reviewed so did not always reflect people's current care needs. One care plan that we reviewed had not been dated and another had not been reviewed since March 2016. None of the care staff had completed risk assessment training which would have helped them to understand their responsibilities regarding assessing risks to people's safety and working in a safe environment, such as not using a hoist without completing up to date moving and handling training. Some individual risk assessments contained information about behaviours that people may display if they became upset or distressed. However, there were no clear guidelines for staff about how they could support people to manage these behaviours or things that may trigger these. Care records showed that when people had become distressed staff had not always been aware of how to support them appropriately.

The service had one hoist and the provider advised us that it was regularly serviced. When looking for evidence to support this we found that there was no service record available or renewal date recorded on the hoist itself to show that it had been deemed safe to use. Following the inspection the provider has advised us that they have arranged a further service of the hoist which has confirmed that the equipment is in good working order.

People who were at risk of pressure sores had been supplied with pressure relieving equipment, such as air mattresses. However, records were not in place to show that regular checks had been completed to ensure the settings were correct for the person's weight. Staff were not appropriately monitoring people at risk of weight loss. One person had been regularly refusing meals placing them at risk of weight loss but staff had not been regularly weighing them so were unable to ascertain or monitor how much weight the person had lost. This person also required the use of a hoist. This raised further concerns because staff were not regularly monitoring their weight to ensure that the correct sling size was being used. These regular checks are essential to ensure that the sling is appropriate to meet their needs and to mitigate the risk of a person slipping through the sling.

The service's moving and handling policy had been reviewed in May 2016 and stated that, "All staff are expected to attend annual manual handling refresher training". During our visit we found that only two care staff had attended moving and handling training, but this was some years ago and was out of date. Refresher training had not been organised. Five staff had not attended or been provided with any formal moving and handling training since being employed at the service. This was in breach of the service's moving and handling policy which stated that, 'Two people fully trained in safe handling techniques and equipment,' should assist people who required manual handling equipment, such as a hoist. One person living in the service had been assessed as requiring a hoist for transfers. Rotas confirmed that staff without moving and handling training had been placed in charge of shifts. Two members of staff were on duty during the day and since none of the staff had received up to date manual handling training the service was not following its own policy and staff were using moving and handling equipment without completing formal training. The policy also stated that staff would be provided with information, instruction, training and supervision required to ensure health and safety at work, of employees and others. This also does not comply with the guidelines of the Lifting Operations and Lifting Equipment Regulations 1998 and the national minimum standards set out in the Care Standards Act 2000, which stipulate that staff should be trained in the proper use of manual handling equipment and that refresher training should be received annually. Without completing regular up to date manual handling training it is not possible to ensure that care staff are competent in the use of manual handling equipment and are able to risk assess either their own or the person that they are moving safety. The provider was advised that their policies were not being adhered to and putting people at risk.

People did not live in a well maintained and safe environment. It was noted that the exterior of the building needed some repairs and general maintenance. We also found that some of the bedrooms did not have easy access to hot water and some hot taps within the service did not work at all. Regular checks on water temperatures had not been routinely checked to ensure they were safe. The service had a lack of audits available to show that the monitoring and maintenance of the premises and equipment was on-going. This was brought to the provider's attention. They advised that they had recently had the boiler replaced and had purchased new vanity units for each of the bedrooms and the taps and sinks were to be replaced.

The garden was a hazard and people would not be able to gain access due a broken path posing a significant trip hazard. Furthermore, the garden would not be accessible for wheelchair users or those with restricted mobility and there was no patio area or table and chairs for people to use. A broken fence panel to a neighbouring property with free access from the road to the back of the home did not ensure people's

safety and risk assessments had not been completed to show how the security risks were being managed in the interim of this being repaired. The service did not have night time fire evacuation plans for each person to take into consideration the layout of the building and environment to help keep people safe.

Medication was stored in a locked cabinet in the kitchen. We saw that there was a thermometer in the cupboard for staff to monitor the temperature that the medication was stored at, and on the day of the inspection the temperature was within safe limits. However, staff did not keep a written record of the temperature so it was not possible to see if this was consistently the case. We looked at the Medicines administration records (MAR) for three people, they were completed properly and there were no unexplained gaps. Several people had 'as directed' topical medicines creams prescribed. Each person had their cream stored in their own room. One person's care plan stated that they received their medication covertly. There was no record of this having been approved by their GP or of a capacity assessment having been completed to support this decision. When we spoke to staff about this they told us that the person no longer had covert medication, but this change in need had not been reflected in their care plan.

Some people were receiving homely remedies such as aspirin and cold and flu remedies. A homely remedy is a non-prescribed medication that can be used for the short term management of minor ailment. Staff were not consistently recording when this type of medication was administered to people. We saw that on one occasion staff had re-used a person's MAR sheet by crossing out their name and writing in someone else's name to record the administration of aspirin. Best practice guidelines recommend that, to prevent the over prescription of medication such as paracetamol, the administration of homely remedies should be recorded on a chart. The duration of use should also be recorded so that staff are alerted to when the person should be referred to their GP. We discussed this with the provider who said that they would look into the matter.

The provider told us that care staff received annual medication training from an external company. However, there were no internal systems in place to assess staff competencies and the provider did not carry out medication audits which would have highlighted some of the concerns that we identified.

The service did not have acceptable infection control procedures in place. Instead of paper towels, there was only a material hand towel available for hand drying in the staff toilet and there was also a lack of hot water in some bedrooms and bathrooms for staff to use. This is a potential source of infection and does not comply with the National Institute for Health and Care Excellence (NICE) infection control guidelines (2012). The service had not completed regular audits on infection control, which would have highlighted this issue.

These failings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have systems in place for the provider to monitor people's level of dependency and to help assess the number of staff needed to provide people's care. We were advised that the staffing levels consisted of two care staff on duty from 08:00 until 14:45 and two care staff on duty from 14:30 until 21:15. Night staff consisted of one wake staff member and during the day the manager and administrator were supernumerary. The manager advised that they would often arrange for extra staff to stay so that people could go out on activities; but when looking at the rota for the past three weeks no extra staff had been organised. Although one staff member was on duty at night, it was noted that one person required the use of a hoist to mobilise safely, which requires the support of two staff members. With the present staffing numbers there would not be enough staff on duty to facilitate this at night. We found the provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of the people using the service and keep them safe at all times. They had also not risk assessed

the staffing levels at night and put appropriate plans in placed to ensure people were safe in all circumstances.

Although there were sufficient care staff available during the inspection to meet people's individual care needs, on discussion with the care staff it was pointed out that people's choice of activities could be restricted because there were not always enough staff available to support people's care needs in the service and support people in the activity of their choosing. As an example it was established that when people attended college they had to attend the same course as only one staff member would accompany them, no consideration had been given as to whether this was the best course for each person's abilities and the decision was made on the basis of available staff only. It had not been explored by the provider whether further staff were needed to support each person's choice of course and what options could be considered if required to achieve this for people.

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

The service had a recruitment policy in place and this stated that appropriate checks would be completed on new staff which helped to keep people safe. We viewed one new staff files and this contained the required documentation and included health declarations, identification, references and checks from the Disclosure and Barring service (DBS). The service had a probationary period in place and also a disciplinary procedure which could be used when there were concerns around staff practice and keeping people safe.

Certificates were made available to show the services electric, gas and fire appliances had been regularly assessed and safe. People's bedrooms had been recently decorated and were very personalised. One person advised that they had been able to choose the colour of their bedrooms and this was one of their 'favourite colours'.

Inadequate

Is the service effective?

Our findings

Staff had not received the training that they needed to carry out their roles effectively. Five out of eight staff had not attended moving and handling training and two more who had received training but required refresher training due the length of time since their initial training. Other training had not been completed by staff for a number of years and staff had not been supported to undertake training, learning and development to enable them to fulfil the requirements of their role and both keep them and people safe.

New staff had been inducted into the service by someone who had not attended regular refresher training to ensure that their own skills and knowledge were kept up to date and in line with current best practice guidelines. These concerns were raised with the provider during the inspection. New care staff were required to complete an induction when they first joined the service. This was in the form of a booklet that covered the common induction standards, which were the suggested topics covered for new staff. The provider advised that this has since been replaced by the Care Certificate, and we saw that a new member of staff had commenced their employment at the service and that they had been enrolled on the training to complete this. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It was noted that new staff had covered moving and handling and recognizing and responding to abuse and neglect as part of their induction, but the staff member providing the training did not have any evidence of completing moving and handling training and had not attended safeguarding training since 2005. Without having attended up to date refresher courses it is not possible to ensure that they were themselves adhering to current best practice guidelines or imparting the correct knowledge onto new staff members.

Care staff we spoke with confirmed they had attended training in the past, but added they had received limited updates and refresher courses over the last couple of years. Records showed that many had completed training during 2012 – 2014, but limited training had since been done. The provider advised that they had not been monitoring the training of staff and courses had not been organised. They had been part of a consortium some years ago and training had been made available, but since this had ceased they had not found another 'suitable provider.' The provider added, "I could have just sent them on an online course, but I would rather they had face to face, which costs money." Since our inspection the provider had arranged for staff to attend a moving and handling course and Mental Capacity Act training.

Staff had not been adequately supported in their professional development. Documentation showed that care staff had only received two observational supervisions over the last ten months and none of the care staff had received an annual appraisal. The provider advised that care staff would be supervised every 8-10 weeks, but written documentation showed that this had not occurred.

These failings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS). The MCA provides a legal framework for making

particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

The provider did not demonstrate an understanding of their responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. They were also unable to provide documentation to support which people within the service had lasting power of attorneys in place for their finances and/or care. Care staff had not completed training in respect of the MCA and DoLS and had limited understanding of the subject. People who used the service had limited communication skills and were not always able to share their views. We saw evidence that where decisions had been made on behalf of people the least restrictive option was not always chosen and that people were not always given choices about how they wished to live their lives. Prior to the inspection we had received information of concern in the form of a safeguarding alert that people living in the service had not been appropriately supported to vote during the European Union referendum. At the time of the inspection this issue was still under investigation by the local authority safeguarding team. Concerns had also been raised that people attended the same college courses each year and that these were not always in line with their capabilities and about a general lack of people's voice in their care. This meant that the service had not consistently operated in line with the requirements of the MCA.

Care plans did not contain assessments of people's capacity to make day to day decisions. For example, where bed rails were in place there was no evidence in care plans that an MCA assessment or Best Interests meeting had taken place regarding this, this was also found to be the case with one person who had previously been receiving their medication covertly. The manager had not made any DoLS referrals to the Local Authority in accordance with new guidance to ensure that restrictions on people's ability to leave the service were appropriate and how best to live their lives with constant supervision for their safety. Feedback from one relative included, "We have recently had a long discussion and are now in the process of getting MCA forms completed for [person's name] health needs and LPA etc. We think that this process could have been started sooner."

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

Where people required additional support to ensure their nutritional needs were met, this was not always effectively managed. Although staff told us that people had access to snacks and drinks throughout the day care staff were not consistently following the procedure for recording people's food and fluid intake. We looked at the food and fluid charts for a person, dated from 24 September to 27 September 2016. On each day the person had refused food at one of the meal times. There was no evidence to show that staff had offered the person any alternatives to the food that they refused. One snack was recorded as being offered each day in between breakfast and lunch time. However, the person had repeatedly refused this and there was no record of snacks being offered at different times of the day. The person had been prescribed a food supplement; we saw that this was only given to the person on one occasion during this time period. We looked at the person's care plan and saw that it had not been appropriately updated to reflect their changing needs. There was sufficient food available, although it was noted that some food had passed its best before date. This was brought to the provider's attention.

People were weighed monthly; however where people were at risk of weight loss staff did not take

appropriate measures to monitor this. For example, one person had been identified as being at risk of not eating or drinking enough, which placed them at risk of weight loss. However, the last recorded weight for the person was on 27 August 2016 which meant that staff were not accurately monitoring the person's weight loss and there was no evidence that the service had made a referral to the dietician or speech and language therapist for further support and advice. The provider confirmed that the service did have the equipment needed to weight this person, but it had not routinely been done.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In general care staff had an understanding of people's nutritional likes, dislikes, dietary or cultural needs and how these were to be met. None of the present people living at the service were on a special diet, but one did have dietary needs. The service had a four week menu and this showed that there was a varied menu and that people were offered choice and a healthy balanced diet. Care staff advised that the menus were only a guide and they would offer different options for the main meal where people may want an alternative. During lunch people were noted to have different meals and this was due to either choosing something else, or it had been changed by the care staff due to the texture not meeting the person's nutritional needs. One person stated, "I did not like chilli con carne, so I chose to have fish and mash." People spoken with stated they received enough to eat and one added that snacks were made available during the day. Most people were able to eat independently, but some needed the occasional prompt and encouragement and care staff were observed offering assistance as needed.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, opticians and dentists. However, care staff were not consistently proactive in gaining support from healthcare professionals such as the dietician or speech and language therapist, when a need had been identified. Information about people's care was found to be disjointed and was held in several places including, a correspondence file, a folder and a daily diary. Recording information in several places leads to an increased risk of inaccurate and poor documentation. Feedback from relatives regarding healthcare included, "[Person's name] has always had any medical needs tended to and their rate of infection has dropped over her time at the Paddocks" and "Over the last few months [person's name] has experienced increased difficulties in their ability to eat and drink, they are very independent so attempts to help them more have not always succeeded. We do not know whether there could be an underlying cause, but medical intervention is needed to determine this."

Requires Improvement

Is the service caring?

Our findings

One relative's feedback included the comment, "I believe that [person's name] is afforded dignity and respect both in her personal care needs and for being the person she is. I have always seen staff being supportive and accepting [person's name] even when things have been difficult." During the inspection we found that although care staff knew the people they were supporting very well they did not routinely respect people's privacy and dignity. Staff were heard asking loudly if people required the toilet and one was heard shouting "[person's name] toilet please." We also found that written language was not always respectful. A person was described as 'attention seeking' in their care records, which is not professional or respectful language. Other words that had been recorded in the care notes included, 'stubborn,' 'ignoring staff,' and '[person's name] stopped moaning.' Another incident had been recorded was where one person had been incontinent of urine and care staff had recorded, '[person's name] was already wet and kept lying and denying that they were not. Although they would say sorry after realising their mistake.' This was brought to the provider's attention.

People had not been given an opportunity to give any formal feedback or make decisions about their care and support. We found no written documentation to show that people had been supported to express their views about their care and support. Resident meetings had not been organized to provide people with the opportunity to give feedback on their views about the service or to enable them to make decisions about their care. When asking about meetings within the service the deputy manager advised, "We do not have meetings as such. We do not formally note it down. We are here a lot and get feedback, but we do not have meetings or anything formal." Most people at the service had relatives involved in their care and regular contact and visits had been made. The provider advised that relatives would be routinely involved in reviews and decisions on care, but it was noted that formal reviews had not taken place for over a year. None of the people at the service had access to an advocacy service who could offer independent advice, support and guidance to individuals.

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

One relative reported, "[Person's name] is always well groomed and looks cared for. Their nails are done and their hair is styled whenever we see them. On unannounced visits their demeanour and presentation are as good as when staff know we are coming. They are offered choices, as far as they can be, e.g. clothes and activities. Staff generally read [person's name] moods and adjust the care given by them." Another added, "Overall we are very happy with the care at this time." Each person living at the service was clean, tidy, dressed appropriately for the weather and looked comfortable. People were seen to be relaxed with care staff and given the time and support they needed.

Many of the care staff had worked at the service for a number of years and knew the people very well. People were observed with care staff and were able to show through their body language that they were happy and comfortable with the care being provided. Care staff were able to show they knew how to communicate effectively with each person and they had a good understanding of people's needs. One relative reported,

"[Person's name] has multiple problems which they cannot communicate well, but the staff understand them and strive to do the best for them. Their lack of verbal communication and overall ability to understand and contribute are big barriers to being heard, but I think that all team members interpret her behaviours, reactions and words as best they can and will ask us if they felt that something needs addressing." One staff member stated, "We all get along and we know the people well."

Care staff were heard offering people choice with drinks and observed interacting with each individual. Feedback from relatives included, "[Person's name] is not able to express much choice and therefore their choices are confined to the very immediate, e.g. what drink they want, what clothes they want to wear, or whether they want to do a puzzle or another activity. In these respects [person's name] is offered and communicates their desires." One staff member was noted to be doing a 'Zumba' DVD with four people and encouraging them to participate. Laughter was heard as they each tried to take part. Another staff member was seen sitting on the floor doing jigsaws with someone. Another was seen sitting next to one person and rubbing their leg and talking with them. The person was seen trying to take the staff member's ring off. They stated, "[Person's name] likes rings, they will take them off and put them back on again and then put them on you again." This interaction went on for some time, but the person looked relaxed and both were content in each other's company.

Inadequate

Is the service responsive?

Our findings

We received differing opinions from relatives when we asked for feedback regarding their experience of the care provided to people living in the service. One relative told us that they were satisfied that their loved ones needs were being met and that the services that they received were, "Tailored to their needs directly and changes are made as their ability and capabilities change." They went onto say that they found staff to be, "Approachable and receptive to providing effective and responsive care." However, another relative expressed concern about the effectiveness of the communication between the provider and the care staff and how autonomous the staff were allowed to be when making decisions about the immediate needs of people living in the service.

Many of the people living at the service had been there for many years and assessments had been completed when they first came to live at The Paddocks. The care plans we reviewed were basic and only contained general information about each person. They did included information about people's life histories, including their family background and friends and family who were important to them. Other information held about people's care were in several places including, a correspondence file, a folder and a daily diary, which made it disjointed and often difficult to easily obtain a clear overview of people's care and any changes that had occurred.

People's desired outcomes and what they hoped to achieve and experience whilst living at the service had not been recorded. There was little evidence either during discussions with people or in records to show that the service had actively involved people who lived at the service and their relatives in setting goals and ensuring each person had choices in the way they lived. The service had not made sure that people's views had been taken into account and care plans in place did not make sure that people received care that was person centred. Feedback from relatives included, "I have subsequently raised the poorer communication regarding this and annual reviews and had an acknowledgement from [provider's name] that things could have been better. It is not that we do not get a response, but that the actions following are not always followed through promptly."

We were advised the service had a key worker system in place, but when people were asked who their key worker was; those who were able to communicate verbally were unable to tell us. One person added that, "They liked having a key worker as it was someone they could talk with and understand them better." We were advised by one person that they could go to bed when they wanted to, but noted from care notes that restrictions had been made when people wanted to go to their rooms during the day. This included, "[Person's name] was in their room at the start of the afternoon shift. They stayed there and relaxed with our permission." Another record showed that a person had asked to go to their room in the morning but this had been refused by staff. There was no reason or assessment on the person's file to explain why the person was being restricted in this way.

At our inspection we identified the service had limited meaningful activities in place for people. No written evidence was available to show that people had been involved in planning their activities or leisure time. Activities consisted of going for a walk to the shops, having a foot spa or spa bath within the service, visiting

the local shopping centre and table top activities. Some outside activities had been organised for individuals and included bowling, swimming, horse riding and a weekly evening club. People living at the service were unable to safely gain access to the garden area for recreational purposes, due to the path being uneven and poorly maintained and the garden area not being secure due to a missing fence panel. People had requested that they wished to attend outside educational courses, but on discussion with the provider these had not been organised or facilitated, even though the new college term had started. One relative stated that although some outside activities had been organised the service used to provide a holiday every couple of years when their relative first moved in, but this had not occurred for a long time.

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

The service had a set form to record any concerns or complaint they received. The last recorded complaint received by the service was noted to be 1998. The service had a complaints process, but this did not include details of any time scales or how this would be investigated. The provider was advised that this needed to be updated to include this information. The service had not produced any guidance or information on making complaints in a suitable format for the people who lived at the service.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We had concerns about the day to day management and oversight of the service. There were a number of areas that the provider had not ensured had been completed and including; staff training, regular staff supervision and appraisals, medication audits, infection control audits, monitoring the environment to ensure it was well maintained and safe and adhering to the Mental Capacity Act and Deprivation of Liberty. The provider did not have a system in place for ensuring that there were sufficient staff on duty to keep people safe and people were not consistently supported to have choice and empowered to make decisions.

There were limited systems in place to assess and monitor the quality of the service. This meant that the provider did not have a clear oversight of the issues affecting the service and they did not demonstrate to us an understanding of the requirement to implement quality assurance processes. Records were not available to show that the provider had carried out regular audits to assess the quality of the service and to drive continuous improvements. Although some equipment checks had been carried out and certificates were in place to show that these were safe, environmental checks had not been carried out to help ensure people's and staff's safety.

The provider had gained feedback from relatives in the form of an annual questionnaire, but this had not been collated and a report had not been made available to people. The service did not have systems in place to gain the views of people who lived at the service or a formal system in place to help empower people and get them involved in the running of the service. Meetings had not been organised and the provider advised that these had occurred in the past, but it was not something that they routinely did. Although there was an annual quality questionnaire for people who lived at the service, this had not been completed for a number of years and people had not been given the opportunity to feedback on the service through annual questionnaires. No staff meetings had taken place and feedback from care staff around the management and running of the service had not been gained. Feedback from relatives included, "I find that on the whole the staff and management are responsive, but that better communication between the two would speed actions up. I believe that sometimes the staff do not feel very valued and would feel more able to take decisions in the interests of the residents should there be more open discussion."

The service was clean but there were no clear procedures and processes relating to the regular monitoring of the service and the health and safety of the service was not adequately maintained. Issues around infection control were raised during our visit and the service did not have an audit in place that would have highlighted these concerns before our visit.

The provider did not have oversight of staff practice and support processes; a training programme was not in place to ensure that staff's skills and knowledge were regularly updated and they had not ensured they had gained written evidence of training completed with previous employers.

We found no evidence to demonstrate how the manager was moving the service forward and focussing on ways to constantly improve. There was no service improvement plan and they did not link to any local networks to ensure they were updated on new information and legislation related to adult social care and

best practice guidance relating to their service or for people living with a learning disability.

Many of the policies and procedures seen stated they had been reviewed during 2016, but it was noted that the documents had information from previous regulations that had now been replaced. Records in the service were not being accurately maintained so as to show clearly how the care and support for people were being delivered including how decisions were made in their best interests and with their involvement.

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

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect, including supporting the autonomy, independence and involvement of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse in accordance with this regulation because the provider's systems and processes were not established and operated effectively to prevent any potential abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users were not always met to ensure their wellbeing and health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established and operated an effective and accessible system for identifying, receiving, recording, handling and

responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.