# Swanton Care & Community (Autism North) Limited

# Seaham View

## Inspection report

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## Ratings

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

## Overall summary

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, and to provide a rating for the service under the Care Act 2014.

We inspected Seaham View on 18 September and 1 October 2014 The inspection was unannounced. Our last inspection took place on 5 November 2013 and we found the service was meeting all essential standards.

Seaham View is registered to provide accommodation and personal care for up to 12 people. During our visit the home accommodated 12 young adults with learning disabilities and autism.

The home had a registered manager at the time of our inspection. 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

# Summary of findings

People using the service were not able to tell us about their experience of care during our visits but we observed how people were cared for, spoke with other professionals, staff and management.

Staff working in the service described the service as “dangerous, unsafe and neglectful” as they were not properly trained to manage people’s complex needs.

On the days of our inspections we saw people were not well cared for and serious concerns regarding the safety of people using the service were identified. We saw first-hand the inability of staff to manage people’s complex needs, people were not engaged in meaningful activities, the environment did not meet people’s needs and staff demonstrated limited knowledge of caring for people with autism.

# 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. The arrangements to keep people safe were inadequate because we saw examples in records and were told by staff working in the home, that people were frequently assaulted by the people they lived with.

We also found the arrangements where people were restrained and secluded were inadequate. This placed people at risk of abuse because practices were contradictory to best practice.

Staff responsible for caring for people had not been appropriately recruited. None of the staff we spoke with had worked in care before and had limited understanding of how to support people who have a range of complex needs such as no speech, harmful behaviours and property destruction.

We looked at the risk management plans to ensure people's safety and found there was an absence of care planning and risk assessment. This meant there was no consistent approach to care by the staff responsible for caring for people, placing them at risk of harm.

We looked at the arrangements for management of medication and found these were inadequate for example staff had limited knowledge of the medication people were prescribed and its effects and where people required their physical health care needs monitored it was unclear from records if this took place.

**Is the service effective?**

Inadequate

There was a lack of suitable arrangements in terms of appropriately supporting the registered manager and other staff. The service was employing staff who did not have the necessary skills and experience to meet the needs of this vulnerable service user group and the service was failing to supervise and appraise their abilities to deliver safe and appropriate care.

We found the service did not comply with the requirements under the Mental Capacity Act 2005. There was an absence of capacity assessments and a failure to use alternative methods of communication to involve people in decisions regarding their care.

The physical environment was not conducive to people's needs because promotion of independence was not a focus of the service.This was demonstrated by the fact appropriate kitchen equipment was not available for people to use and people had no timetable of activities that promoted independence and daily living skills.

**Is the service caring?**

Inadequate

The service was not caring. We found that staff working in the home did not have the skills and abilities to engage people in activities which often meant people's needs were not being met. We witnessed first-hand staff failing to interact and engage people in any kind of meaningful activity.

We found staff had a poor understanding of people's needs. For example showed no understanding of people's interests and how these could be used to inform effective care planning.

# Summary of findings

We found the service had no regard for best practice such as 'Valuing People Now 2010.' People were not supported to have positive and meaningful relationships with people outside the home, people had few or no friends and were not supported to make friends. People were not actively supported to seek employment, or join clubs independently, and be active members of their community.

We found no evidence to suggest people were involved in any planning of their care and where people had communication tools such as story boards these were not used by staff which demonstrated a failure to engage people effectively.

**Is the service responsive?**

**Inadequate**

The service was not responsive. We found care plans were not individualised and person centered and where the service had sought the expertise of health professionals their advice had been ignored. We saw instances where psychologists had been involved in supporting people to express themselves sexually. The advice and guidance had not been incorporated into any care plan and staff were unaware of its existence.

The service had not embraced any best practice in relation to guidance that was relevant to the service. For example National Institute Of Clinical Excellence (NICE) guidance in relation to autism care was not a feature within the service and consequently people were receiving poor standards of care.

**Is the service well-led?**

**Inadequate**

The service was not well-led. We found the service had received audits from external organisations but concerns raised during the inspection had not been identified by either external organisations or the care provider.

We found staff were not adequately supervised and appraised and staff informed us they had not received any form of supervision for periods of over a year which had consequently led to care practices not being monitored or supervised by senior managers. This placed people at risk of receiving care which was not effective or safe.

# Seaham View

**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 checked 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.

We inspected Seaham View on 19 September and 1 October 2014 The inspection was unannounced.

This inspection was carried out because we received information stating people working in the home were unable to manage people's complex behaviours and this meant they were "scared" of the people using the service. The information provided came from a person who did not wish to be identified.

The inspection team consisted of two inspectors and a specialist advisor who was a clinical psychologist who specialised in learning disabilities and autism.

On the days of our inspection we spoke with 12 members of staff including the registered manager and other senior managers.

People using the service due to their complex care needs were unable to engage with us and tell us their experience of care. We observed how people were cared for, looked around some areas of the building including people's bedrooms, bathrooms and communal areas. We also spent time looking at records, which included 12 people's care records, and records relating to the management of the home.

Inadequate

# Is the service safe?

## Our findings

We found the systems in place to keep people safe were inadequate and people were placed at risk of abuse. People's care for example had not been appropriately planned and delivered to ensure the safety and well-being of people. Where people displayed behaviours which challenged the service appropriate arrangements were not in place to prevent the risk of harm.

We were told by staff that people using the service were often assaulted by other service users. The way this was described to the inspectors showed no insight as to how inappropriate it is for someone to be in fear of being assaulted in their own home. Staff we spoke with were able to tell us about different types of abuse including physical assaults, We had been told by staff, and records showed, people using the service were regularly assaulted by their peers. We saw no management strategies had been implemented to guide staff about the inappropriateness of people being assaulted in their own home by those they lived with.

We looked at the incident records of all people using the service and found concerning information regarding the compatibility of people who lived together. The records showed us that assaults occurred between people for unprovoked reasons, such as walking past each other in corridors. Assaults included people being poked in the eyes and other unprovoked assaults. We found the nature of assaults alarming in that people attempting to poke eyes out, strangle, hit and pull hair. Such assaults exposed people and staff to an obvious risk of harm.

We saw concerning information in people's files such as rules about behaviours. One service user's records contained instructions for staff to remove items from the person's room as a sanction for challenging behaviour and only return the items in return for good behaviour. The Department of Health Guidance for Positive and Proactive Care would have regarded this as poor practice because it is punitive and does not promote positive behaviour. We would have expected to have seen positive behaviour support plans in place to support people who had complex behaviour which challenged the service.

We saw other information displayed in the kitchen of Seaham View where nutritional intake in relation to fruit had been restricted in regards to one person with no details in care records why. Again this is regarded as poor practice because failing to have appropriate reasons for preventing people access to fresh fruit could be seen as restrictive and punitive.

We saw incident records where people had been secluded and restrained when their behaviour was deemed by staff to be "unacceptable and inappropriate." The service had failed to plan and deliver care effectively by taking into account the advice and guidance from health professionals which could have minimised the use of restraint and seclusion. We saw in some people's records they had been taken and locked in rooms for expressing themselves sexually. One person's incident records stated a person had been held in the sensory room for over two hours and were unable to leave until they were "sensible."

We saw in each of the people's records they had received detailed support from a psychologist who provided instructions to staff on how to support the people. The instructions had been ignored in that there were no care plans in place for supporting people to express themselves sexually and none of the staff were aware of the information contained in the psychologist's report. Instead staff resorted to punitive sanction such as restraint and seclusion when people required appropriate understanding and support. This placed people at risk of psychological harm.

We saw examples in records where staff had used a variety of methods of restraint, some they had received training in and some they had not for example the use of "prone and supine" restraint both methods are floor restraints and can cause serious harm. These were methods staff at Seaham view had not been trained in but were using which placed people at a real risk of harm.

We found there was an absence of an appropriate value and attitude base. For example when we asked staff what their values were to caring for people with autism and learning disabilities they struggled to understand what we meant by values and no one we spoke with was able to articulate a coherent position. When we asked for a copy of the service's statement of purpose, we were given a document referring to a previous provider's organisation and the content of which was not specific to the people living at Seaham View and their needs. Failing to establish an appropriate value and attitude base when restraint is used places people at risk of abuse because it becomes unclear that restraint is only ever used as a last resort.

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# Is the service safe?

The BILD Code of Practice (2010) 3rd Edition for the use and reduction of restrictive physical interventions does not outlaw specific techniques but requires that the physiological and psychological risks of each and every technique taught is assessed and documented. There was a total absence of restraint risk assessments and care plans for people using the service as nobody had one in place.

We were concerned looking at the records of some people to find physical restraint had been used for periods of up to an hour and in some cases techniques being used placed people at significant risk of harm. For example records written showed that supine and prone restraint was used and people had sustained bruising which was explained and unexplained as a result of the restraint. The method can lead to significant harm. Guidance Positive and Safe: April 2014 has condemned the use of prone restraint.

The Department of Health / Department for Education and Skills joint guidance (2002) Guidance for Restrictive Physical Interventions describes the risks of techniques such as supine restraint and the Code of practice sets out a clear process to be followed if such approaches are to be justified and should be included in behaviour support plans. People at Seaham View did not have behaviour support plans or restraint plans and therefore they were placed at risk of abuse because there was no clear reasoning when and how restraint should be used.

Where any form of control or restraint is used the service must have suitable arrangements in place to protect people against the risk of control or restraint being unlawful or otherwise excessive. There were no suitable arrangements in place at Seaham View.

The use of restraint should always be risk assessed to ensure that appropriate techniques are used; restraint is practised in a way that protects dignity and respect; and restraint is discussed, agreed and documented in advance. There should be an identified documented plan that sets out preferred measures to prevent and minimise the use of restraint, which is reviewed if the person's needs change, and restraint should only be used as a last resort and is the minimum response necessary for the shortest possible time. There should also be an assessment of the person restrained and others involved in restraint for signs of injury and any emotional or psychological impact. We could not find evidence of any of these recommendations in place

We were told by staff who had worked in the service for a long period of time they had to restrain people up to 10 times a week. Five staff members told us many staff were frightened and avoided intervening when users became distressed. The staff members told us they had been hurt as a consequence of this and said it put people at risk. Staff told us many incidents were not recorded because people "couldn't be bothered."

We looked at the Company policy which clearly stated where restraint is used it should be clearly recorded and incorporated within a care plan and should be done in accordance with correct legal authorisation. We found no evidence of these practices in relation to how the service and staff were utilising restraint and therefore it was impossible to ascertain if the use of restraint at the service was being carried out lawfully and in accordance with the requirements of the policy.

We looked at the care records of all 12 people using the service and identified serious concerns.

We would have expected to have seen comprehensive care plans which detailed information about people's diagnoses, the nature of people's behaviours and the strategies and interventions that staff should follow to ensure people received safe care and the agreed methods of restraint.

The 12 care plans that we looked at contained limited information relating to the strategies and interventions staff should follow to ensure people's complex behaviour was well managed and the agreed approaches to restraint. The provider's policy on restraint clearly states that where restraint is used this should be incorporated within the person's care plan. We found that staff were not following the policy.

During our inspection we talked with staff about the behaviour people displayed and how it impacted on the delivery of care. Staff described the service as "unsafe, depressive, and dangerous." Staff told us that people using the service were "neglected because the staff caring for them did not know what to do".

We saw the inability of staff to manage complex behaviours at Seaham View. On 18 September 2014 one person became very distressed and anxious during the inspection. We saw the person being placed in physical restraint by five members of staff and escorted to their bedroom. Staff informed the inspector the person was unable to leave the

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space until they became calm. Inspectors found that there was no reference in the person's care plan regarding seclusion and also no plans in place for the use of restraint and equally no process from learning from incidents when restraint may have had an emotional or psychological impact on the person. This placed the person at risk of harm and the use of restraint was potentially unlawful because the service did not have appropriate care plans in place and had not sought correct legal authorisation from the relevant authorities to use such intensive forms of restraint.

Following the restraint and seclusion, we spoke with two of the members of staff responsible for caring for the person. From our discussion it was apparent that they had no awareness of the person's care needs including sensory impairments regarding noise and how the physical environment was not conducive to supporting people with these difficulties. Furthermore, they also informed the inspectors that they had not received training in autism and were not, when questioned, able to understand basic components of the characteristics of a person who is autistic. This confirmed staff were not skilled and competent to care for people with autism and placed people at risk of abuse because their care needs were not met.

We saw another incident where another person was very distressed and the staff responsible for working with them stood, watched and failed to intervene. The staff's failure to respond and intervene, whilst the person injured themselves, is an omission that placed the person at risk of harm or actual harm. Inspectors looked at the care records of the person and found there were no strategies and interventions to guide staff as to how to support the person with their distress.

Staff working in the service did not have the required competence and skill to meet the needs of people who use the service. This was a breach of Regulation 21 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We found that effective recruitment procedures were not in place within the service. The service is required to operate effective recruitment procedures in order to ensure the persons employed have the skills and experience which are necessary for the work performed.

Staff we spoke with reported that they had never worked in a service for people with autism before and therefore had no previous experience to compare their practice to. Staff told us they had previously been employed in none related care backgrounds. Although it is recognised staff can be caring compassionate and knowledgeable regardless of their previous background it was evident at Seaham View from talking with eight care staff they were unable to demonstrate any significant skill or knowledge relating to the people they cared for, this was demonstrated from the poor interventions on managing complex behaviours and poor interactions we observed.

The service supports individuals with a variety of challenges including aggression, property destruction, self-injurious behaviour and harmful behaviour. There were no care staff at Seaham View who were able to demonstrate any particular expertise in developing and implementing interventions to assist individuals with challenging behaviour and the staff did not hold recognised relevant qualifications in this area.

The registered manager recognised that both she and other staff didn't have the skills to meet the people's needs. We were told that training in Positive Behavioural Support was being planned, although both staff and people had been in situ for many years. We saw little to suggest that those supporting people had any specialist knowledge in relation to supporting people with a learning disability or autism. This was demonstrated by staff having great difficulty in effectively engaging people in any meaningful activity. Failing to recruit staff with relevant skills and competence places people at risk of harm.

This was a breach of Regulation 9 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the arrangements in place from the management and safe administration of medication and found improvements were required. For example we identified one person who was prescribed a certain antipsychotic which had a side effect of excessive eating and irritability. We spoke with two members of staff and the manager about the person's care and we were told the person was "obsessed" about food. We asked the manager if they were aware of the side effects of the medication and were told "we are not doctors or nurses that work here why would we know?" This raised our immediate concerns that staff gave people medication on a daily basis and were

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unaware of its side effects The manager and staff failed to acknowledge the person's medication may have contributed to their complex needs and the "obsession" regarding food may have been directly related to their medication.

We also looked at the care records of two other people who had been prescribed medication due to staff expressing difficulties in managing the person's behaviour. We found people had been prescribed medication without physically seeing their doctor and care plans had not been updated to reflect the medication prescribed and how it was intended to be used and also how it would be monitored. Some of the medication prescribed had significant health implications and it was unclear from records what systems had been put in place to monitor the physical health of people who were prescribed particular antipsychotics.

We found the lack of insight into prescribed medication placed people at risk of harm because staff were unaware of its physical side effects and also did not have appropriate documented plans in place to monitor the physical health care needs of people.

We looked at how the building was maintained and was conducive to people's needs and found improvements were required. For example, the service had an industrial kitchen that was not suitable for service users to use, and the small domestic kitchen on one unit for people was not fit for purpose. The kitchen door was missing, there were unfixed and unpainted skirting boards and there were doors missing from a kitchen unit as well as a lack of facilities such as cooker, microwave, toaster and fridge. All the utensils we would expect to see in a functional kitchen were absent. The manager told us there was a plan to remove the kitchen because its presence contributed to people's challenging behaviour as they would focus on the kitchen and associate it with food. This demonstrated people were not treated with dignity and respect and a focus of empowerment and autonomy were not a focus for the service. It also demonstrated the service did not adequately maintain the environment.

Our tour of the building also identified there was broken furniture within the communal court yard that people had access to. We brought to the attention of the manager the furniture could have been used as weapons to assault and hurt people. We informed the manager of this at 10:30am on the morning of the 1 October 2014 but nothing had been done to remove the broken material when we left at 3:30am on the morning of 2 October 2014.

We asked the manager what adaptions had been made to support people who had sensory impairments. We found no adaptions had been made and no health professionals had been involved in carrying out an assessment of the building which could have supported the service to have made changes which would have benefited people who had impairments in regards to noise and light. The service acknowledged some people's complex behaviour was contributed to by the physical environment of the home but yet nothing had been done to rectify the situation, which could have meant people were supported in an environment which met their needs.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Inadequate

# Is the service effective?

## Our findings

People using the service had complex needs which often meant making difficult decisions regarding their care was not always possible. We looked at how people were involved in decisions regarding their care and treatment and found no assessments relating to people's capacity had been completed other than when assessing a person's Deprivation of Liberty Safeguards (DOLS).

While the lack of documentation is a serious failure in itself, it was also unclear whether any capacity or best interest's assessments had been carried at all, as required under the Mental Capacity Act 2005. As a consequence, the service was unable to demonstrate the legal basis for decisions made on behalf of people without their consent.

Due to the needs of people using the service we looked at how different communication systems were used in the service to effectively engage people in decisions and found no evidence of any augmented or alternative communication being used despite many of the people having little or no speech. This falls short of the requirement under the Mental Capacity Act 2005 to take all practicable steps to help people make decisions, communicate in ways appropriate to people's circumstances and permit and encourage people to participate as fully as possible in acts or decisions affecting them.

We looked at one person's records and found a support plan from a speech and language therapist had been sought to support the person with communication through the use of "story boards". However, none of the staff we spoke with were aware of the existence of the assessment or the instructions which were provided. This meant staff were not following the advice and guidance of health professionals and where people could have been involved in decisions regarding their care they were not.

We looked at the Deprivation of Liberty Safeguards documentation for nine people and spoke with the manager. We were told that no safeguards were in place for the use of restraint or seclusion and that authorisation had only been sought in relation to people leaving the building as there was a key pad locking system. This raised serious concerns that people may have been unlawfully deprived of their liberty at Seaham View and not have the protection of the Deprivation of Liberty Safeguards. Depriving individuals of such legal protection exposes service users to a risk of harm and abuse

From looking at records relating to restraint we also found the service had not followed the principles laid down within the Mental Capacity Act 2005. The reason being was their was no documented agreed approaches to the use of restraint and no best interest assessments either which meant the rights of people were not being upheld to participate and agree the methods of care when a person is in distress.

We asked what one thing would improve the service, one support worker said "the guys could do a lot more", "we used to have activity plans, but I don't know where they have gone" and "nine times out of 10 the activity is just a walk". As a minimum we would have expected each person to have an individual timetable of activities encompassing daily living, self-help, recreational and educational/ vocational activity. We looked at the activity records of all 12 people and the information we were told about people spending their time walking was a reflection of what we had been told. We struggled to find any information in reported activities to suggest people spent their time doing anything meaningful.

One person's relative we spoke with told us they had raised concerns previously with the service as their relative was often bored and spent "far too much time sat in the home alone, without anything constructive to do."

We observed the activities people were engaged in during our inspection and found they were not meaningful. For example we saw people sat staring out of windows for long periods of time whilst staff sat in the same room observing but not interacting, we also observed people looking through catalogues whilst staff stood close by but not interacting. This meant people were not being encouraged to engage in meaningful activities.

We found that there was little to engage people within the home. One lounge had an empty protective frame for a television, which apparently had been missing for some time after it had been broken by a person using the service. Scattered around the home were toddler's toys, such as small plastic figurines, Disney jigsaws and crayons. Staff were not aware of the possible stigmatising effects and the benefits of encouraging age appropriate activities.

Inadequate

# Is the service effective?

This was a breach of Regulation 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We looked at one person's care records and found reference was made to the use of a TEACCH approach (Treatment and Education of Autistic and Related Handicapped Children) but, upon questioning, a senior member of staff said "I don't know", despite them being responsible for the individual's care plans and having worked in the service for several years. This meant the service referenced evidence based material but the member of staff were spoke with had no understanding of its purpose or function or even how it could benefit people.

We looked at the arrangements in place for monitoring people's physical health care needs and found the service did not follow best practice by implementing care records such as Health Action Plans. The Department of Health has published guidance in relation to Health Action plans as it is recognised as good practice to involve people in the planning of their health, psychological and emotional needs. We spoke with the manager about the guidance regarding health action plans and she was unclear of what information was required or where the guidance could be obtained from. Health Action Plans were introduced specifically because people with learning disabilities often have unmet physical healthcare. It was concerning that the manager was unaware of the best practice regarding planning and maintaining the physical healthcare needs of their client group.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We interviewed eight staff and talked to them about training and supervision. Staff we spoke with all confirmed that they had not received supervision for long periods of time. Some suggested one year whilst others suggested almost two. All staff confirmed that the registered manager had not completed any supervision at all.

We asked staff if they ever received learning by way of reflective practice. Staff were unclear as what was meant by reflective practice so they were asked how they had learnt from incidents such as when people attempted to strangle them or hurt them. Staff subsequently reported that no reflective practice took place.

There was a lack of suitable arrangements in terms of appropriately supporting the registered manager and other staff. The service was employing staff who did not have the necessary skills and experience to meet the needs of this vulnerable service user group and the service was failing to supervise and appraise their abilities to deliver safe and appropriate care. As a result the service was placing service users at risk of harm through inappropriate practices carried out by staff who were insufficiently qualified, skilled, experienced or supervised.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

# Is the service caring?

## Our findings

We looked at the way people were cared for and found care was inadequate. For example increasing independence, maintaining personal safety and well-being and ameliorating and managing challenging behaviour were not a focus of the service. During the time we were at the service we saw no evidence of people being supported to be independent and develop daily living skills.

We did not see any people engaged in meaningful age-appropriate activity during our inspections at the service. We saw one person sitting in a living area at a table with nothing on it while three staff sat in the same room some distance from them. On two occasions a resident barged into the office and wanted to close the windows. Staff dealt with this inconsistently. On another occasion a person stood in the hallway with one sock hanging from their foot while staff stood by without intervening.

We had spent a total of approximately 30 hours in the service which broken up were 10.5 hours on 18 September 2014 and 18.5 Hours on 1 October 2014. During this period we observed no positive interactions with staff and people. Staff often sat in the same rooms as people but failed to engage them in any activities. Staff did not appreciate the time and attention that was required in order to support people appropriately.

Where people were engaged in activities in our presence they were of infantile nature; for example, playing with toddler's toys. Staff whom inspectors spoke with, including the manager, had no understanding how this can stigmatise people and be unconducive to their development.

We looked at the records of all 12 people living at the service and found the range of activities limited to going for a walk to a drive in the car. There was no information in people's records to demonstrate the principles of Valuing People Now 2010 were being embedded in the service by engaging in meaningful activities that developed social inclusion or any of the principles of supporting people with complex needs.

We spoke to the manager and staff and neither were aware of the principles of care set within Valuing People Now. They failed to appreciate the importance of ensuring people had fulfilling and meaningful lives. Failing to follow and embed basic principles of care is detrimental to the well-being of people at Seaham View and places them at risk of poor care.

We asked the staff how people were offered choices in their care and found activities were decided by staff and people's views were not taken into account because staff failed to use any forms of communication people understood or developed forms of communication to involve people.

The use of equipment such as storyboards to aid communication supports people to understand the care they receive and also supports them to make choices were not being used. If people were provided with the appropriate methods of communication, this allows for greater understanding and reduces their anxieties and agitation which can lead to challenging behaviours due to their needs not being met or understood.

People were not actively supported to be independent and develop daily living skills. No person using the service had a plan to support them to develop daily living skills such as cooking. The kitchen in the home was not appropriate to meet people's needs and promote learning and independence which meant people were restricted in their development as young adults.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

# Is the service responsive?

## Our findings

Staff told us people who use the service often assaulted each other and this was confirmed from the records we saw. The way this was described to us showed no insight as to how inappropriate it is for someone to be in fear of being assaulted in their own home. There was no evidence of any form of intervention for challenging behaviour beyond basic management strategies and pharmacological treatment. For example we saw when people displayed behaviours that challenged they were referred to their doctor for the use of medication.

Whilst this may have been appropriate we would have expected to have seen comprehensive care plans detailing the intended use of the medication and monitoring for its effectiveness. We would have expected to have seen behavioural support plans and assessments which targeted the behaviour which challenged the service.

We found the service was disorganised. The senior members of staff we spoke with were unable to locate a specific care plan relating to arrangements for taking one person out into the community. We spoke with one staff member who had been supporting the person on the morning of 1 October 2014 and they were unaware of the plan's existence, or the procedures which should be followed. This demonstrated staff did not follow the guidelines which were in place for people which were essentially there to ensure people received safe and appropriate care.

We were advised by staff that people could be restrained at least 10 times a week. We were told that many staff were frightened and avoided intervening when people became distressed. Staff told us they had been hurt as a consequence of this and said it put people at risk. We were also told incidents were not recorded because people "couldn't be bothered". Failure to record incidents means that people's care could not be appropriately planned and delivered, consequently placing them at risk of receiving unsafe and inappropriate care which was not responsive to people's needs.

We saw examples of where strategies and interventions had been provided by health professionals relating to the management of sexualised behaviour and effective communication. None of the advice provided had been incorporated into a plan and when we spoke with staff they were unable to tell us about the guidance provided or the strategies or interventions that should be used. This meant that important information for the care and well-being of people was not being followed.

The Department of Health Guidance Positive and Proactive Care:reducing the need for restrictive interventions clearly sets out what the expectations are for caring and managing people who have complex behaviours. Within the guidance it is detailed how services such as Seaham View should incorporate positive behaviour support and the use of functional assessments as a core value for supporting people. The service did not incorporate any elements of the guidance. The manager and care staff working in the home when questioned did not have any understanding of the appropriate guidance which should be followed when caring for people with behaviours which challenged. This meant staff were not always able to respond to people's needs in accordance with best practice.

The 12 care records we looked at contained no details relating to the predictability of people's behaviour which meant that staff were not aware of the triggers that could potentially cause serious harm to people and others using the service. Six staff we spoke with told us people were "neglected because the staff caring for them did not know what to do." Failing to provide comprehensive care plans and assessments meant people's needs were not always met and we saw this from the staff's inability to manage complex behaviours such as the incident involving the restraint and seclusion which we witnessed on 18 September 2014. There were no plans in place for the use of restraint and equally no process from learning from incidents or taking into account the psychological impact this had on the person and referencing this within the person's care records and incident records.

The NICE Guideline in relation to Autism is directly relevant to the services provided at Seaham View and this was not embedded within the service and there was little or no regard for them at all. When we spoke with the manager and staff they were completely unaware of the existence of such guidance and we had to bring it to their attention.

The service is required to take proper steps to ensure that service users are protected against the risk of receiving care and treatment that is inappropriate by means of planning the delivery of care to meet their individual needs and ensure their welfare and safety as directed by the Health and Social Care Act 2010 and the associated regulations.

Inadequate

# Is the service responsive?

The service is also required to follow, where appropriate, good practice guidance issued by professional and expert bodies such as the NICE Guideline which is directly relevant to the services provided at Seaham View. There was no apparent use of best practice and staff were unaware of any guidance which directed their practice.

This was a breach of Regulation 9 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

# Is the service well-led?

## Our findings

We found there to be a limited quantity of audits carried out by the care provider which had taken place. All of the audits that were available which included audits by external organisations failed to identify any of the serious issues identified during our inspection.

This indicates that, from a senior management level, not only had the service failed to operate an effective system of quality monitoring and risk assessment but, as a result of that failure, the service had failed to identify the serious issues and risks affecting the service.

The service had not provided sufficient clinical and operational expertise to support the service. The service employed and had access to health professionals such as occupational therapist, speech and language therapist, a psychologist and psychiatrist but yet their overview and input to the service was minimal. We saw that some people were referred to health professionals within the community learning disability team we found the advice and guidance given was not always followed. We spoke with visiting health professionals on both days of our inspection and they commented the staff lacked the ability to understand the functions of individuals and plans which had been put in place for supporting the staff were not being adhered too.

In addition, the service was disorganised. We found that many of the walls of the house were posted with notices for staff but there was no apparent order to these and the two offices we spent time in were untidy as were many parts of the house, which emphasised there was no sense of the home belonging to the people who lived there.

Having observed incidents on 18 September 2014 we were concerned that these had not been recorded. When we spoke to staff about incident recording, staff informed us incidents happened on a daily basis where people using the service were assaulted by their peers, restrained by staff or where staff are assaulted by them but these are not always recorded because most of it had become “the norm” or “people can’t be bothered”.

Failing to ensure that staff record all incidents has placed both people who use the service and staff at real risk of harm. If incidents are not recorded then it is significantly less likely that triggers for particular behaviours will be identified and subsequently managed appropriately. This increases the likelihood of difficult behaviours occurring and incidents of restraint occurring, placing both people who use the service and staff at risk.

By failing to ensure that staff recorded all incidents the service, other professionals caring for people do not have a complete picture of what is happening at Seaham View, whether in respect of individual people or the service as a whole. The service did not regularly assess and monitor the quality of the service and operate effective systems to protect service users from inappropriate or unsafe care and treatment. The service was also unable to make important changes to the care and treatment provided as there was no reliable analysis of incidents that resulted in harm or had the potential to result in harm. This meant the service was prejudicing the ability to prevent incidents of harm or potential harm occurring. This placed both people and staff at risk of harm.

The service has failed to follow best practice and national guidance which is applicable to the vulnerable service users cared for at Seaham View. The Department of Health Guidance Positive and Proactive Care: reducing the need for restrictive interventions April 2014 was issued following the Winterbourne View scandal which clearly states that where people display challenging behaviour, positive behaviour support should be a core value within the service and people should have positive behavioural support plans.

Staff and management at Seaham View could not demonstrate any knowledge of the above guidance, the principles of positive behavioural support or the support plans that should be embedded. At the time of the inspection the service had introduced positive behaviour coaches however the two staff identified as coaches were unable to demonstrate any skills or knowledge in positive behaviour support when questioned by inspectors despite them having completed training.

The service could not demonstrate any understanding of Valuing People Now 2010. This is evidenced by way of lack of social inclusion and also how staff failed to engage people in a way that promotes positive well-being. The principles of Valuing People Now 2010 are factors which have not been taken into account which means the service has not learned from poor practices in other services such as Winterbourne View.

Inadequate

# Is the service well-led?

We found where people received increases in their medication, people were not always seen by a clinician. Records relating to people showed telephone calls made to the consultant. The home manager informed us the clinician rarely visited the home and prescribing was done following phone calls. There was no further information provided in people's care records about monitoring the use of the medication, its benefits or what psychological therapies would be used to support people.

We observed from the care records people had received increases in antipsychotic medication to manage their complex behaviour and although this may have been entirely appropriate joint statements by both the Royal College of Psychiatrists and British Psychological Society clearly sets out the expectations of managing complex and challenging behaviour (Royal College of Psychiatrists (2007) Challenging Behaviour: A unified approach and Clinical and service guidelines College Report CR 144).There was a absence of this guidance embedded at Seaham View.

The use of antipsychotic medication can have serious health implications for people and failure to understand this means that people are at risk of harm. The service has not demonstrated any understanding of why people displayed certain behaviours or implemented plans and strategies to support people and, in the absence of more detailed records justifying and monitoring such action as set out in the above guidance.

The service is required to protect people and others who may be at risk of harm (including staff) against the risks of inappropriate or unsafe care and treatment. The service also is required to do this by means of the effective operation of systems designed to regularly assess and monitor the quality of services provided and by identifying, assessing and managing risks relating to the health, safety and welfare of people. Where necessary, changes should be made to care and treatment provided in order to reflect information from the analysis of incidents that resulted in harm or had the potential to result in harm. The service is also required regularly seek the views of service users, to enable the service to be informed as to the standard of care and view of people, we saw none of these aspects occurring and this was contributed to by the lack of communication tools being used.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.