Voyage 1 Limited

West Drive

Inspection report

1 West Drive
Arlesey
Bedford
Bedfordshire
SG15 6RW

Tel: 01462835490
Website: www.voyagecare.com

Date of inspection visit:
23 July 2019
24 July 2019
30 July 2019

Date of publication:
03 September 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

West drive is a residential care home providing personal care to nine young adults who may be living with a learning disability or autistic spectrum disorder. The service can support up to 10 people. West drive consists of an adapted building which can accommodate eight people and a bungalow which can accommodate two people. Seven people were living in the adapted building and two people were living in the bungalow. People have their own bedrooms with en-suite toilet facilities and share communal areas such as the kitchen, dining room and garden.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 10 people. Nine people were using the service. This is larger than current best practice guidance. The size of the service had some negative impact on people using the service. People had complex support needs and required high levels of staff support. The service was very busy and noisy. This was identified as something that made people anxious or upset. Restrictions necessary for some people were having a negative impact on other people being able to access areas of the service such as the kitchen.

People's experience of using this service and what we found:

People were not kept safe from potential harm and abuse because known risk to people were not effectively being monitored by the management and staff team. People were required to have food, fluid or behaviours monitored to keep them safe and this was not happening. People's risk assessments identified physical restraint to support people where people had not been assessed for these techniques to see if they were safe for the person.

Some staff members were not trained in working with people with complex needs including communication and were unable to support people safely. Staff members had not been given the opportunity to get to know people before supporting them which led to people feeling upset and anxious. The service was using a high proportion of agency staff who did not have training or an effective induction to support people safely.

The service was very dirty and in need of cleaning. This meant that people were at risk of infection. The premises needed some work to make it safe for people to use. The service was not always suitable for the needs of the people living at the service. People needed a high number of staff to support them which made

the service very busy. People found this difficult to manage as busy environments were identified as reasons for their anxiety.

People were not being supported to eat a balanced diet and there was a lack of choice with regards to food that people could eat. People were supported to see health professionals when they needed this support although this was not always promptly sought.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. Restrictions on people were not always put in place using the correct legal procedures. Capacity assessments and decisions in people's best interests were not always completed.

The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people had a lack of choice and control and limited independence. For example, people were restricted from areas of the service based on other people's needs. Menus were developed by staff with no input from people who lived at the service. People were not supported in their preferred communication methods meaning they could not make choices about their support.

People were not always supported with kindness, respect and compassion. Staff did always respect people's choices and dignity. People were not supported in a person-centred way that met their needs and preferences. Staff did not always understand peoples preferred communication methods and did not understand the reasons for people's behaviour support plans.

The provider had not promoted a positive person-centred culture which promoted good outcomes for people. Audits and checks at the service were not effective in identifying where improvements could be made. Feedback was not being collected from people and their relatives to inform and possibly improve the service.

Following our inspection, the provider took immediate action to start making improvements and give people a better experience of the people using the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection:
The last rating for this service was good (report published 14 March 2017). At this inspection the service has deteriorated to inadequate.

Why we inspected:

The inspection was prompted in part due to concerns received about alleged unlawful restraint and the premises not being suitable to support people with complex needs. A decision was made for us to complete a comprehensive inspection to examine these risks.

We have found evidence that the provider needs to make improvements. Please see information in the report.

You can see what action we have asked the provider to take at the end of this full report. The provider has acted to mitigate these risks following the inspection and these have been effective.

Enforcement:

We have identified breaches in relation to safe care and treatment, staffing, premises, safeguarding service users from abuse, consent to care and treatment, person centred care and good governance.

We took urgent action to prevent the provider from admitting people in to the respite room at the service. We also required the provider to send us monthly reports detailing the actions they were taking to monitor the service in relation to our findings.

Follow up:

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

West Drive

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

This inspection was carried out by two inspectors.

Service and service type:

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not present during our inspection. The registered manager left the service with immediate effect during our inspection. The service was receiving management support from the operations manager and a service improvements manager during our inspection.

Notice of inspection:

This inspection was unannounced on 23 and 24 July 2019. Two inspectors visited the service on these dates. One inspector visited the service on 30 July 2019 and we gave the service 24 hours' notice of this visit.

What we did before the inspection:

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work within the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection:

We spoke with one person who used the service and one relative about their experience of the care provided. We observed other people being supported by the staff team. We spoke with three support workers, a senior support worker, the service improvement manager, the operations manager, two members of the quality support team, a registered manager who was supporting from another service, the director of quality and the chief operating officer. .

We reviewed a range of records. This included five people's care records which included all aspects of care and risk including medication records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed information around people's DoLS and restrictions. We looked at staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We attended a conference call and had a meeting with the provider, the local authority and the CCG on 25 and 26 July to discuss the findings of the inspection so far and to inform the provider of actions we would be taking.

After the inspection:

We stayed in contact with the provider to collect evidence about improvements being made at the service. We looked at information around complaints and compliments and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant that people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People had risk assessments in place for behaviours that may challenge others, moving and handling, going out in the community and support to eat and drink enough. However, these risk assessments were not effective at reducing risk to people.

● People's risk assessments indicated that staff may need to use physical restraint in crisis situations. Risk assessments were not clear about which techniques were safe to use for the person. There was no evidence that people had been assessed as being safe to be supported with physical restraint techniques. People's risk assessments told staff to only use physical restraint if '[Person] presents a serious or immediate risk of harm to themselves or others.' This meant that staff did not have clear guidance as to what an immediate risk may look like. One staff member told us, ''I am not sure if everyone is written up for physical intervention. Managers are in the process of going through everything.'' People were at risk of being supported with physical restraint which may not be safe for them.

● People's risk assessments and Deprivation of Liberty Safeguards DoLS identified that some people were at risk of malnutrition or dehydration. Some people were required to have food, fluids and weights monitored to ensure that they were safe. These were not being recorded which made it unclear how much food or fluid a person had throughout the day. This meant that people were at risk of malnutrition or dehydration.

●One person had a restriction in place around how many fizzy drinks they could have during the day. On the first two days of our inspection the weather was extremely hot, however no consideration had been given to this person needing more fluid. Staff continued to follow the restrictions in place for the person and refused this person's requests for drinks from the kitchen. This person's fluid intake had not been recorded. This meant that this person may have been at risk of dehydration.

● People living with epilepsy were not being monitored for seizure activity overnight, although this had been identified as a control measure in their risk assessments. Equipment was not being used to monitor people and staff had not recorded that regular checks had been completed. This meant that people were at risk of harm if they had a seizure overnight.

Risk assessments and care plans were not effective. People were at risk of harm as risk assessments were unclear or were not followed by staff. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider sent us evidence that the use of physical restraint and people's DoLS were being reviewed. The provider also sent evidence that staff were recording and monitoring food and fluid intake for people who needed this support.

● A relative told us, ''I think [Person] is overall safe but we are in the midst of a big change. Things should be far better.''

Staffing and recruitment

● The provider was using a high proportion of agency staff to cover staff vacancies. The service was going through a high turnover rate of staff meaning that there were a lot of new staff working at the service.

● Although there were enough staff to support people, agency staff and some new staff did not have the necessary experience or training to support people safely. Agency profiles we reviewed showed that agency staff did not have training in supporting people with autism, complex needs or physical restraint which had been identified in people's care plans. A relative said, ''There are enough staff but a lot of them are agency or new. [Person] will get upset sometimes and new staff may not understand what [Person] means.''

● We observed several occasions during our inspection where people were not supported according to their care plans and risk assessments. Staff were not speaking to people in their preferred communication methods or engaging with them in a meaningful way. This was because some staff had not been given the time to get to know people before supporting them. A staff member told us, ''It is not the agency staff's fault, but it is not a good idea to use them as it is always different people. All the changing staff makes it difficult for people.''

Staff did not have the necessary training or understanding to support people with complex needs. This meant that people were at risk of receiving unsafe care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider sent us evidence that all staff were going to receive training in areas such as physical restraint, supporting people with autism and supporting people with behaviour which may challenge others.

● The provider also sent us evidence that agency staff would not be able to work at the service unless they had the necessary training and experience to support people safely.

● The provider had robust recruitment procedures and checks in place to ensure that staff were suitable to work at the service.

Preventing and controlling infection

● On the first day two days of our inspection visit the service was visibly very dirty. A stained clinical waste bag was in a person's bathroom over the two days of our inspection, despite us alerting staff to this on the first day. People's bathrooms and toilets were dirty and in need of a deep clean. Used latex gloves and a used mop were being kept in the same room as a person's clothes. A fly catcher light in the kitchen had a large number of dead flies located in it. Areas of the service such as walls, floors and banisters were dusty and had several stains on them. A relative told us, ''There are often dead insects under [person's] bed and around the toilet.'' This meant that people were at risk of harm from unclean premises.

The level of cleanliness at the service meant that people were at risk from infection. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the third day of our inspection the provider had arranged for deep cleaning to take place and the service looked much cleaner because of this. The provider also sent us evidence that staff would be supported to maintain high cleaning standards going forward.

Systems and processes to safeguard people from the risk of abuse

● Although systems and processes were in place to safeguard people from abuse these were not always used effectively. There had been several incidents in the past which had not been reported to the safeguarding team or the CQC by the registered manager. The service improvement manager and the

deputy manager had sent these through recently before our inspection.
● People's communication included behaviours that may challenge. These behaviours were not being effectively managed as staff did not know people well and were not always following people's care plans.
● Staff were allocated to support people based on their support needs. However, during the second day of our inspection we found a high proportion of the staff team standing in the kitchen, eating food after the evening meal. One person shouted for support as they were worried that another person may hit them. Staff members then left the kitchen to support the person. This meant that people were at risk of abuse from other people who used the service.

People were at risk of abuse from other people as staff were not following people's care plans effectively. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider sent us evidence that peoples care plans were being reviewed and shared with staff to ensure that people were safeguarded from some people's behaviours that may challenge.
● There was a safeguarding policy in place at the service which was out of date. A quality team member ensured this was updated during our inspection.
● Staff members received training in safeguarding. One staff member said, ''I would report anything to the manager straight away or call the whistleblowing number or the local authority.'' However, we could not be sure that the correct process was followed after staff raised concerns, due to the large number of incidents that had not been reported before our inspection. This meant that incidents were not being investigated so that measures could be put in place to protect people from harm.

Learning lessons when things go wrong
● The provider had not learnt lessons when things went wrong. Loud noises and busy environments had been identified as triggers for people's behaviours that may challenge. However, action had not been taken to identify how this risk could be reduced. On the first day of our inspection there were plans to introduce another person with complex support needs in to the service. This would have further impacted on the busy and noisy environment.
● The provider had an action plan in place following audits and visits from external stakeholders such as the local authority. Actions to prevent things going wrong had not been completed, although this action plan had been in place for several months. This meant that actions were not always taken when things went wrong.

Using medicines safely
● We observed people being supported with their medicines. People were supported using good practice and with their preferred method of taking their medicines. Staff members completed checks of medicines as they administered them to ensure that errors were not made.
● Staff received training in medicines. Staff members we spoke with had a good understanding of how to safely support people with the administration of medicines.
● Some people had protocols in place for 'as and when required' (PRN) medicines. However, some PRN medicines did not have protocols. This meant that staff may not be sure when to administer these medicines. After our inspection the provider sent us evidence that PRN protocols were being reviewed and put in place where they were missing.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Some staff and agency staff did not have the right training, skills or experience to support people effectively. We observed that staff members did not always understand what people were trying to communicate to them in communication methods such as sign language. We observed staff members using behaviour de-escalation techniques for people, however staff did not understand the purpose of these. This meant that people became more anxious as a result of techniques not being used effectively.
- Records showed that agency staff did not have the correct training to support people effectively. Some staff and agency staff had not worked at the service long enough to get to know people living with complex needs. Staff told us that some people needed to know care staff well to reduce people's anxieties. We observed these people being supported by agency staff who were new to the service. This meant that people were not always supported effectively.
- Agency staff did not receive an effective induction before starting to work at the service. Inductions consisted of a checklist completed by agency staff on their first day at the service. This checklist also included 'introduction the people we support'. These were not signed off by an experienced member of staff. We could not be sure that agency staff had enough time to get to know people with complex needs based on these inductions.
- A large number of staff did not have physical intervention training. Of the 21 staff members employed at the service, 10 had physical intervention training which was in date. One staff member said, ''The training could be better here. I think it is getting better now but a lot of training is online.'' This meant that people would not be supported safely if they required these interventions.
- Staff members received supervision, and records confirmed this, however staff members told us that this was infrequent and were not effective. One staff member said, ''I do not receive the right amount of supervisions. I feel under supported.''

Staff did not have the necessary training or understanding to support people with complex needs. This meant that people were at risk of receiving unsafe care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider sent us evidence that all staff were going to receive training in areas such as physical restraint, supporting people with autism and supporting people with challenging behaviour. Staff would receive this training within 4 weeks of our inspection taking place.
- The provider also sent us evidence that agency staff would not be able to work at the service unless they had the necessary training and experience to support people safely.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Some people had restrictions on their liberty which were appropriately authorised under the DoLS. However, we saw that some people had restrictions in place that were not a condition of their DoLS. For example, one person's clothes were kept locked away in a separate room. Another person's personal items were locked away in a separate room. There was no evidence recorded that this was in people's best interests.

● The restrictions on one person meant that areas of the service such as the kitchen and downstairs toilet needed to be locked at all times. These restrictions impacted on other people using the service who did not have to have these restrictions in place. We observed several occasions where this caused distress to people. One person was walking up and down the corridor by the kitchen saying 'I am thirsty' in a loud voice. This person would have been able to make their own drink if the kitchen had not been locked. Another person became visibly anxious when they were asked to leave the kitchen so that the person who was restricted could not enter.

● Staff received training in the Mental Capacity Act, however our observations showed that this was not always understood by the staff team.

● Other than DoLS put in place other aspects of peoples care and support were not assessed. Where people had been assessed as lacking the capacity to make decisions the correct decision making process to take the decision in a person's best interest were not followed.

● Regular reviews of DoLS were not completed to ensure that measures in place were the least restrictive options for people.

People were being restricted in areas where restrictions were not necessary, and reviews of restrictions were not taking place. This meant that people's freedoms and choices were unnecessarily restricted. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider sent us evidence that DoLS and restrictions placed on people were being reviewed with immediate effect.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always supported to maintain a balanced diet as food and fluids were not being recorded in line with people's assessed needs. People's requests for drinks were refused based on restrictive practices in place for people. This meant that people were not able to access drinks when they chose to do so.

● On the first day of our inspection several food items were out of date in the kitchen. These were removed following the first day of our inspection.

● A member of the quality team spoke to us about how people were involved in choosing food and being involved in meal preparation. The quality team member told us that staff knew what people liked and prepared this for them. There was no evidence that people had been involved in menu planning. The quality team member told us that there were now plans to involve people in this area by sourcing photographs to

help people make choices.
● People were not being supported to eat a varied and healthy diet. Menus we reviewed showed that limited choices were offered to people. One person said, ''We have the fruit bowl, but it is empty. I think we need more of it.'' On the third day of our inspection actions were being taken to improve the choices available for people.
● On the third day of our inspection, referrals were made for people to be seen by a dietitian to advise the staff team how to support people with a healthy diet and appropriate food and fluid intake.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to see healthcare professionals such as GP's and the behaviour support team. However, sometimes referrals were not made in a timely manner. One person who was showing signs they were unhappy would have benefitted from seeing other professionals to rule out potential reasons for their distress. However, there were delays in accessing the support for this person. This meant that the person was not supported with effective care and their distress continued.
● During our inspection we observed that support was being put in place by a behaviour support team and autism specialist to help people who display behaviours that may challenge. We also saw that staff were being supported to support people more effectively with these needs.

Adapting service, design, decoration to meet people's needs
● Consideration had not been given to the complex needs of people living in the premises. People's support needs meant that there were a lot of staff in the service and areas of the service such as corridors, the kitchen and the entranceway were not fit to accommodate a large amount of people. This had a negative impact on people who found busy environments difficult to live in. If people wanted personal space then they needed to go to their bedrooms, or other areas such as the garden or sensory room which was not always people's choice and may have caused unnecessary isolation and anxiety.
● There was a respite room at the service which was not fit for purpose. However, on the first day of our inspection there were plans to accommodate a person in these premises. The provider took action to ensure that this room would not be used.
● On the first two days of our inspection the premises needed some immediate re-decoration. There were numerous holes in the walls, and this was particularly true for one person's bedroom. The service visible looked very faded and dirty in some areas which indicated that it needed re decoration.
● The premises had not been adapted to meet people's complex communication needs. There were various notice boards throughout the premises in areas such as the hallway and the dining room. These were to let people know what activities were on offer or options for meals. However, these were either not in use or contained written information which people could not understand.
● On the third day of our inspection works were underway to make improvements to the premises. The provider had planned these improvements for some time.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed. However, assessments in areas such as sensory needs were not completed fully or were missing information. For example, one person living with autism had it identified that they communicated with 'body language of their own choice'. There was no information about what this body language would look like. This meant that staff did not have information available about how to effectively communicate with the person.
● People's care plans were not updated following changes in people's needs. This meant that staff did not have access to up to date information about how to support people.
● The way in which restrictions were placed on people and people not being assessed for physical

interventions stated in their care plans meant that care was not being delivered in line with guidance and the law.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not always supported in a kind and respectful manner. For example, we saw one staff member physically take a carrier bag away from a person who was trying to see what was inside. The staff member said, ''No that is not yours, they are not for you.'' The staff member made no attempt to explain why the person could not see what was in the bag and made no attempt to offer the person another activity.
- We heard another staff member say to a colleague, ''Watch out, [Person] is kicking off again.'' This was not respectful language.
- During a handover period we observed staff members greeting each other but not greeting people using the service. This meant that people could feel ignored by staff members.
- We also observed some kind interactions between people and the staff team. One staff member had sourced some different smelling lotions for a person to use as this decreased their anxieties. The staff member said, ''It is about trying to make it fun for [person] inside the house.'' Another staff member was seen to be supporting a person well with their de-escalation technique to reduce anxiety.
- People's care plans were mostly written in a kind and respectful language.

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

- People and their relatives were not involved in their care planning. Care plans stated that people could not be involved in care planning due to their capacity and that care plans were made based on observations. There was no evidence that relatives or people who were important to the person had been involved in reviewing care plans. There was no evidence that staff had tried different methods of communication to involve people in their care planning.
- Staff did not always offer people informed choices. A relative said, ''Most things that [family member] does we suggest. Staff do give choices, but this is not always done in the right way. There is no encouragement given.'' We observed that staff did not always respect people's choices. For example, one person wanted to go out in to the community and this was not possible. No alternative of activity was offered to this person.
- We observed some people being able to make choices about taking part in activities such as baking a cake. However, for people who were non-verbal we did not see many choices being offered and people spent a large portion of the inspection walking up and down corridors.
- Following our inspection, the provider told us that they would be introducing key worker meetings to help people be involved in their care planning.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not always promoted. One person wanted to use the kitchen, however a staff

member stood in the kitchen doorway and said, 'No, you don't need to come in here now.' This staff member then closed the kitchen door. Another person was spending time in their bedroom however two staff were sitting in the bedroom with the person. This person was walking back and forth in their room whilst the two staff members were talking to each other. This meant the person did not have time to themselves.

● People's dignity was not always respected. One person's clothes were kept separately from their bedroom. This person's clothes were kept in a store cupboard which contained used latex gloves and a dirty mop. The persons clothes were stored untidily in a big pile in this room. This did not respect the person's dignity.

●People's bedroom doors had numbers written on them in black marker pen. This did not show dignity or respect.

● We observed staff members knocking on people's doors before entering their bedrooms.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive personalised care that met their needs. Observations of the staff supporting people and the way in which people acted showed that people were anxious for a large majority of the day during our inspection. Staff did not always support people to reduce their anxiety.
- Some people communicated their distress using physical behaviours such as hitting other people. People's care plans identified that a trigger for people were loud noises and busy environments. Throughout the inspection areas of the service became very busy and noisy due to the number of people living at the home and the high number of staff supporting people. People were walking around the service with their hands in their ears and were visible very distressed when trying to communicate with staff supporting them. No consideration or measures had been taken to try and reduce this for people and this meant that people's needs, and preferences were not being met.
- One person spent most of their time in their room. Staff told us that this person did not like noise, busy environments, being supported by unfamiliar staff or having lots of changes of staff. On the first day of our inspection this person was being supported by a member of staff who had not worked with them before. This meant that known triggers for this person were not being considered. Other people had it identified that changing staff throughout the day increased their anxieties. However, people were supported by different people frequently during the inspection. People were visibly more anxious when these changes happened.
- We saw one member of staff using a de-escalation of behaviour technique with one person to help them with their anxiety. The staff member rushed through this technique and then walked away from the person. This resulted in the person becoming visibly more upset and anxious. This meant that though the staff member knew the process of how to support the person, they were not able to implement it effectively.
- People could not access all areas of the house to take part in activities due to other people's care needs. When one person was supported to use the kitchen, other people were supported to leave the kitchen by the staff team. This meant that people could not always do the things they wanted to do throughout the day.
- People's care plans were completed in detail however there was limited information about people's likes, dislikes and preferences. A relative said, ''We wrote about a list of foods that [Person] likes but no one knows where it is.'' This meant that new staff members did not have information to support people in a personalised way.
- Some staff we spoke with told us how they wanted to keep people at the centre of their care. One staff member said, ''It's all about the people. How we can make their lives easier and put them in control.'' However, our observations showed that this was not fully understood by all staff supporting people.

● People's care plans were not always regularly reviewed

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Some people communicated with signs and gestures or other non-verbal methods. We observed that when people used these communication methods staff did not always seem to understand what people were communicating. For example, one person was signing and asking for a biscuit. A staff member said ''Yes, you will see [family member] on Friday'' and then walked away from the person. The person became visibly distressed afterwards which showed that the staff member did not understand what this person was communicating.
● Some staff and agency staff did not have training to support people with different communication needs which meant they were unable to communicate with people effectively.
● People's care plans identified that people used signs and gestures to communicate, however did not give specific details as to what these were. This meant that staff would not know what people were trying to communicate and people would become anxious or frustrated as they could not be understood.
● There were no communication aids such as pictures or symbols in place to help people communicate. A member of the quality team told us that they would be looking in to this in areas such as choosing from a menu or choosing activities.

People were not receiving personalised care based on their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider sent us evidence that people's care plans and communication methods were being reviewed and further training and support was being put in place for the staff team.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to go out in to the community if appropriately trained staff were available to support them. People took part in an array of activities such as swimming, going to the gym, going for a local walk or using the car to go for drives. However, due to a lack of appropriately trained staff activities were sometimes cancelled which meant that people could not always access the community when they chose to do so. The provider was looking to employ a staff member solely as a driver so that people could access the community on a more regular basis.
● People were not supported to take part in meaningful activities in the house. One staff member said, ''It is difficult to engage people because some people cannot tolerate things like paper being in the house. We have no sensory objects or anything like that to engage with people.'' Another staff member told us that things had been improving in this area recently as staff were being encouraged to do activities in the house with people more often.
● People spent a lot of the day walking around the service without purpose or in their bedrooms. There was a large garden area at the service however one person told us, ''I don't really use it though.'' This meant that people were not engaged in meaningful activities throughout the day.

We recommend that the provider looks at ways to meaningfully engage people in activities in the service, in line with people's choices and preferences, current guidance and best practice. The operations manager

and the staff team had already begun to consider areas for improvement in this area.

● People were able to keep in contact with those important to them. Relatives and friends were able to visit people at any time.

Improving care quality in response to complaints or concerns
● Relatives did not always feel that concerns were listened to or acted upon. One relative said, ''I have asked to discuss concerns with higher management, but no contact has been made.'' We could not find a record of this relatives concerns being passed on to higher management. This meant that concerns may not be responded to in a timely manner.
● The service had a complaints policy and procedure in place. This was available in an easy-read format for people to use.

We recommend that the service review how it collects the views of people and those close to them, and how concerns are responded to in line with current guidance and best practice.

End of life care and support
● People were not being supported to make plans for the end of their life at this inspection as this was not necessary due to their age. The service improvement manager told us that this is something that would be discussed with people and those close to them as part of ongoing care plan reviews.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of management oversight at the service which had resulted in poor outcomes for people. Audits had been completed at the service and identified areas for improvement dated back to April 2019 however no actions had been recorded or completed to improve the service. The local authority had completed an audit which resulted in a large action plan being put in place at the service. Actions identified were being completed at a slow pace and there was not a visible impact of these actions having improvements at the service.
- Staff were not clear on the importance of their roles. There were numerous missing records in people's daily notes including the recording of food and fluid, the recording of behaviours that may challenge and how people had been throughout the day. Checks on people living with epilepsy were not being recorded. This had not been picked up as a potential issue by the management team at the service. This meant that people were at risk of known risk factors identified in their care plans.
- Some health and safety checks at the service in areas such as fire were missing. The last recorded fire drill was in March 2019 however the findings from this had not been recorded. A fire risk assessment for the service completed in May 2019 identified that this was an issue however no action had been taken to rectify this. This put people at risk of an event such as a fire. We raised this with the service improvement manager who completed a fire drill immediately.
- Incidents which should have been reported to the local authority safeguarding team and the CQC had not been reported in a timely manner. This meant that the registered manager had not been acting on duty of candour. The service improvement manager had reported these incidents retrospectively.
- The provider has a statement of purpose which references best practice guidance about supporting people with learning disabilities or autism. This includes Registering the Right Support and the use of physical restraint. However, the findings from our inspection shows that this best practice is not being adhered to.
- The registered manager had not been at the service since May 2019 and the service improvement manager and operations manager had been supporting the service since June 2019. However, at the point of the inspection there had not been effective quality performance and audits taking place to action improvements needed at the service and to manage and mitigate risks and keep people safe.

Governance systems were either not in place or were not effective at identifying areas of risk or improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider took immediate action to audit areas of concern identified in this inspection and put actions in place to rectify these concerns.
● Since June 2019 the provider had been allocating additional resources at the service to ensure that areas for improvement were being identified and improved upon.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had not created a positive culture which achieved good outcomes for people. The lack of management oversight at the service meant that people were being supported by staff who did not have the necessary skills and experience to empower them. Staff did not have a good understanding of people's needs and how the environment and staff behaviours could impact on people's experiences.
● The provider was not meeting their legal obligations in terms of the MCA and restraint. People were restricted in areas where they did not need to be, based on other people's need to be restricted. This meant that people were not empowered to used certain areas of the service. The provider was not meeting their legal obligations in terms of the MCA and restraint.
● The provider had limited oversight around whether the service could meet the needs of people. People with complex needs and high levels of staff support had started using the service since our last inspection. The provider had not monitored the impact that this had on people already using the service. This had increased people's anxieties and had a negative impact on people's quality of life.
● Staff members did not include or empower people whilst supporting them as they did not know people well and did not understand people's communication styles or behaviour management strategies. The operations manager told us, ''The staff culture needs improving. We need to provide staff with the training and tools to work with people effectively.''
● Relatives and staff told us they did not think the service had a positive culture. A relative said, ''The service is very chaotic at the moment which can't be doing anyone any good.'' A staff member told us, ''I would not want my family member living here. The service needs improvement and I know the managers are making a lot of changes.''
● On the third day of our inspection we saw that senior management were working to improve the culture at the service. People were able to access areas such as the kitchen and staff members told us that they were being encouraged and supported to work with the management team to improve the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not supported to be involved in the running of the service. The service improvement manager told us that key worker meetings used to happen to collect feedback from people. However, these had not been happening. Following our inspection, the provider assured us that these would be put back in place to help people feedback about the service.
● People's methods of communication were not considered when collecting feedback from them. Some staff members did not understand people's communication styles and there was limited information about how to communicate with people in care plans. Written information about activities were on a notice board however people could not understand this.
● Relatives did not feel engaged with the service. One relative said, ''[Provider] does not communicate unless it is for payments. They do not seek out our views.'' However, family members had been contacted recently to give their views about the service.
● Staff members told us that they were involved in the running of the service and that team meetings took place. Staff members told us that they felt that their ideas were now being listened to more with the

increased management presence at the service.
● Following our inspection, the provider took actions to involve people and relatives at the service including organising regular meetings for relatives to share their feedback. Surveys were also going to be sent out to people and their relatives to collect feedback.

Working in partnership with others
● The management team and staff worked with other health professionals and behaviour or autism specialists where people needed this support.
● Managers and staff from other services run by the provider had been asked to help support the service to improve based on recent feedback from the local authority and this inspection. The provider had also identified areas for improvement at the service and was working in partnership with the staff team to put actions in place to improve the service.

Continuous learning and improving care
● There had not been a culture of learning and improving from incidents or findings from audits.
● In April 2019 the provider became aware of concerns at this service and in early June 2019 they developed an action plan to address the issues. Following this inspection, they sent us an updated plan detailing further improvement actions.
● Members of the management team spoke passionately about how they would make the necessary improvements to the service. The management team said that they had committed to spending their time and focus at the service to better improve people's quality of life.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving personalised care based on their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were being restricted in areas where restrictions were not necessary and reviews of restrictions were not taking place. This meant that people's freedoms and choices were unnecessarily restricted.

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 People were at risk of abuse from other people as staff were not following people's care plans effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were either not in place or were not effective at identifying areas of risk or improvement at the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments and care plans were not effective. People were at risk of harm as risk assessments were unclear or were not followed by staff. 12 (1) (2)

The enforcement action we took:

Notice of decision to restrict admissions. Notice of decision to ask the provider to send a monthly report to the Care Quality Commission detailing how they were going to improve and maintain people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The level of cleanliness at the service meant that people were at risk from infection

The enforcement action we took:

Notice of decision to ask the provider to send a monthly report to the Care Quality Commission detailing the improvements that had been made to ensure that the service was free from infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the necessary training or understanding to support people with complex needs. This meant that people were at risk of receiving unsafe care.

The enforcement action we took:

Notice of decision to ask the provider to send a monthly report to the Care Quality Commission detailing how they had ensured that people were only supported by suitably trained and experienced staff.