Creative Care (East Midlands) Limited

Orchard End

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Orchard End on 26 October and 16 November 2017. The inspection was unannounced. The home is situated in Retford, in North Nottinghamshire and is operated by Creative Care (East Midlands) Limited. The service is registered to provide accommodation for a maximum of six people with a learning disability. There were three people living at the home on the day of our inspection visit. This was the first time we had inspected the service since they registered with us.

During this inspection we found multiple breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

There was no registered manager in post at the time of our inspection, the previous registered manager had left the service in July 2017. 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. There was a service manager in place during our inspection who had taken over responsibility for the day to day running of the service in late August 2017. However they were not registered with the CQC. The provider told us they would ensure a manager was registered with CQC. We will monitor this.

During this inspection we found that the service was not safe. People were not always protected from risks associated with their care and support. Where people needed support with behaviours that may put them or others at risk, there was not sufficiently detailed information for staff about how to support them safely. Systems to review and learn from accidents and incidents were not consistently effective and this meant we could not be assured that action was taken to protect people from harm. Action was not always taken to protect people from improper treatment or abuse. There were a number of safeguarding investigations underway at the time of our inspection visit following concerns being raised about possible abuse.

There were not always enough, adequately trained staff to provide care and support to people when they needed it. Staffing shortages meant people did not consistently receive the support they required. Temporary staff did not always have the necessary training to enable them to provide safe support. Safe recruitment practices were followed.

Medicines were not stored or managed safely. Staff did not always have the necessary training or competency to ensure safe medicines practices were followed and we were not assured that people received medicines when they needed them.

Where people lacked capacity to make choices and decisions, their rights under the Mental Capacity Act (2005) were not always respected. Some people had significant restrictions placed upon them, but a lack of formal capacity assessments meant we could not be assured these were in their best interests. Staff felt supported, but did not receive sufficient training to enable them carry out their duties effectively and meet

people's individual needs.

People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions as support plans did not contain enough information about people's health needs and staff did not always have enough training. People were supported to have enough to eat and drink.

Some staff were kind and treated people with respect, however other staff were focused on tasks and had limited interaction with people who used the service. People were not supported to be as independent as possible. Staff did not consistently have an understanding of how people communicated and this had a negative impact on people who used the service. People's right to privacy was not always respected.

People were at risk of receiving inconsistent and unsafe support as care plans did not provide an accurate or up to date description of people's needs. There were not always a sufficient number of adequately skilled staff to ensure people were provided with the opportunity for meaningful activity.
People and their families knew how raise issues and concerns, however systems in place to monitor and respond to complaints were not effective and people did not have confidence in the provider to manage complaints appropriately.

The provider had not ensured staff had adequate skills and knowledge to provide specialist support to people with complex needs. Systems in place to monitor and improve the quality and safety of the service were not effective and this resulted in poor outcomes for people living at the home. Appropriate action was not taken to analyse and investigate incidents which posed a risk to the health and wellbeing of people who used the service. Swift action was not always taken in response to known issues. Relatives told us communication between them, the service and provider were poor. Staff felt supported and were able to express their views in relation to how the service was run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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.

People were not always protected from improper treatment or abuse.

People were not always protected from risks associated with their care and support. Systems to review and learn from accidents and incidents were not consistently effective.

There were not always enough, adequately trained staff to provide care and support to people when they needed it.

Medicines were not stored or managed safely.

Safe recruitment practices were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions.

Staff did not receive sufficient training to enable them carry out their duties effectively and meet people's individual needs. Staff were provided with regular supervision and support.

People were supported to have enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff were kind and treated people with respect, however other staff were focused on tasks and had limited interaction with people who used the service.

People were not supported to be as independent as possible.

Staff did not consistently have an understanding of how people communicated.

People's right to privacy was not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving inconsistent and unsafe support as care plans did not provide an accurate or up to date description of people's needs.

People were not provided always provided with the opportunity for meaningful activity.

People and their families knew how raise issues and concerns, however systems in place to monitor and respond to complaints were not effective.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective and this resulted in poor outcomes for people living at the home.

Appropriate action was not taken to analyse and investigate incidents which posed a risk to the health and wellbeing of people who used the service. Swift action was not always taken in response to known issues.

The provider had not ensured staff had adequate skills and knowledge to provide specialist support to people with complex needs.

Staff felt supported and were able to express their views in relation to how the service was run.

Orchard End

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, to look at concerns we received about the service and to provide a rating for the service under the Care Act 2014.

We inspected the service on 26 October and 16 November 2017. The inspection was unannounced. The inspection team consisted of one inspector.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us to plan the inspection.

During our inspection visit we spoke with one person who used the service. We also spoke with five members of care staff, the service manager and the provider's area manager. After our inspection visit we contacted the relatives of all three people who used the service.

To help us assess how people's care needs were being met we reviewed all or part of two people's care records and other information, for example their risk assessments. We also looked the medicines records of two people, three staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out general observations of care and support looked at the interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

People were not safeguarded from abuse. This was reflected in comments from people's families who told us they did not feel the service was safe. One person's relative told us, "No it is not safe, there have been lots of safeguarding incidents." Another relative told us they felt that their loved one was unsafe at the service. In addition to this we received feedback from both staff and relatives that they did not have confidence that all staff would report concerns appropriately. This did not assure us that action would be taken to protect people from improper treatment or abuse. Although records showed that some concerns had been reported to the local authority safeguarding adult's team, we were informed about other serious concerns relating to the treatment of people living at the home which had not been reported. We took action to report these issues to the local authority. The local authority also informed us about a number of other recent safeguarding allegations at the service. These incidents remained under investigation at the time of writing this report. The service had not informed CQC of all of these incidents as they are required to do.

Action had not always been taken to ensure people were protected from the risk of abuse or improper treatment. We found that a number of unexplained injuries had not been investigated and consequently referrals had not been made to the local authority for consideration under their safeguarding adult's protocols. In July 2017 the local authority had investigated concerns that a person had sustained a injury and action had not been taken to investigate the cause of this. Despite recommendations being made by the local authority to improve recording and processes in this area, during our inspection we found that this continued to be an issue. We reviewed incident records and body maps for the same person and found multiple injuries where the cause was unclear. For example, one record stated the person had a small cut, the record documented it was 'possibly' done whilst in the garden but no further investigation had been completed into this. Another recent record documented the person had bruising to their eye, again there was no cause of injury recorded and no evidence of follow up. This meant we could not be assured appropriate action was taken to protect people from harm. We wrote to the provider and asked them to take urgent action in relation to this. On 16 November the provider advised us that a system was being implemented to ensure timely action was taken to identify and investigate unexplained injuries. We will check the impact of this again at our next inspection.

The above information was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from risks associated with their care and support. Guidance for staff about physical interventions was not always clear which meant there was a risk of inappropriate and potentially unsafe, techniques being used. For example, records showed staff were regularly using physical interventions with one person living at the home. The person's positive behaviour plan did not include details of how many staff should be involved or specify when the different physical interventions should be used. Staff we spoke with were unsure of what approaches could be used. One member of staff told us, "I was unsure if we could move [person's] hands and prevent them from hurting themselves. We have been told we can." This approach was not reflected in the person's support plan. Furthermore, the service manager told us physical intervention "doesn't really work" with the person and this was confirmed by

records. A record of a physical intervention documented that the person had 'wriggled out' of the restraint. This information was not reflected in the person's support plan and consequently staff had no guidance of what to do if physical interventions failed. This failure to provide staff with details of how to safely use physical interventions placed people and staff at risk of harm. We wrote to the provider and asked them to take urgent action in relation to this. On 16 November we saw that work to improve care plans was underway. We will check the impact of this at our next inspection.

Systems to review and learn from accidents and incidents were not consistently effective. Records of incidents were not always reviewed and this meant the provider had not always taken timely action to protect people from harm. For example, records showed three incidents occurring over a four week period where a person had caused injury to themselves in the same way. The third incident resulted in the person being taken to hospital for treatment. It was only after this third incident that adaptations were made to the environment to reduce the risk. This failure to analyse and learn from incidents of records meant that opportunities to reduce the likelihood of further adverse occurrences sooner may be missed. We wrote to the provider and asked them to take action in relation to this. They told us that they would implement a system to ensure that incidents were analysed and investigated. We will check the impact of this at our next inspection.

We identified concerns about medicines management during our inspection visit. We were not assured that medicines were administered by sufficiently skilled and competent staff. Staff responsible for managing and auditing medicines, and assessing the competency of other staff had only received basic training in the management of medicines. Furthermore staff raised concerns about the adequacy of the medicines training provided to them. This meant we could not be assured that medicines were administered by suitably skilled and competent staff. There had been a recent medicines error reported to the local authority safeguarding team, and during our inspection we identified other concerns about the management of medicines which gave rise to further concern about the competency of staff in this area.

People were at risk of not receiving the medicines they required as staff were not always sufficiently trained. During our inspection visit on 26 October we found there were not always staff on shift who were trained in the administration of medicines. Both people living at the home were prescribed medicines to be given on an 'as required' basis. There were no effective arrangements in place to administer these medicines at night should people need them. We wrote to the provider and asked them to take urgent action to resolve this issue. The provider informed us arrangements were in place for the on-call manager to attend to administer medicines in these circumstances. However, as some managers lived upwards of one hour away from Orchard End this arrangement did not ensure timely support would be provided. The provider also advised us that night shifts would be covered by medicines trained staff. At our site visit on 16 November 2017 we reviewed rotas and found there continued to be multiple shifts planned where night staff did not have medicines training. For example, a staff member who did not have medicines training was planned to work nights on 10 dates in late November and earlier December. We were informed by a team leader that the other night shift would be covered by agency who do not administer medicines at Orchard End. This continued failure to deploy adequately trained staff meant people remained at risk of not receiving the medicines they required.

Medicines were not always stored in accordance with the manufacturer's instructions. For example, we found a medicine which should have been stored in the fridge was stored at room temperature. This could have an impact on the efficiency of the medicine. We discussed this with a member of staff who explained that this was a new medicine with confusing storage instructions. They took immediate action to address this. However, we could not be assured that staff had the skills and competency to ensure the safe and effective storage of medicines. In addition to this, medicines were not always dated when opened. This

meant it was not possible to determine whether medicines were being used within the manufacturers recommended shelf life and posed a risk that medicines may be used when they were no longer effective. We wrote to the provider and asked them to take action to ensure staff with responsibility for managing medicines had the qualifications, competence and skills to do so safely. The provider informed us that key staff would be provided with additional training. We will check the impact of this at our next inspection.

We were not assured that medicines intended to control people's behaviour were always used appropriately. We spoke with a relative who told us that they felt that this sort of medicine was used more frequently than required as staff did not have the skills to prevent behavioural incidents from escalating. One person who used the service was prescribed a medicine to be given 'as required' to help reduce their anxieties and consequent behaviour. Records did not always evidence that this medicine was given as a last resort and administration was inconsistent. For, example an incident record recorded that this person was administered 'as required' medicine when displaying self injurious behaviours. The record did not clearly evidence that all steps detailed in the person's support plan had been tried prior to the administration of medicine, nor did it evidence that the person's behaviour was placing them or others at significant risk to necessitate the administration of this type of medicine. During the course of our inspection we also received concerns that 'as required medicines' had not always been available to people when needed. We shared these concerns with the local authority safeguarding team and this was still under investigation at the time of writing this report.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient numbers of staff available to meet the needs of people living at Orchard End. One person living at the home was in hospital at the time of our inspection visit and daily support hours were being funded to enable staff to visit and support them. Prior to our inspection we received concerns that this support was not always delivered. Records confirmed this to be the case and the service manager explained that they had not always been able to fulfil these visits due to staffing levels and other external factors such as problems with transport. This had resulted in the person not always being visited by staff. There was a risk that this lack of consistency may have a negative impact upon the person's wellbeing.

We found that temporary agency staff were not always adequately trained to ensure people's safety. We reviewed one person's support plan which stated that the use of physical interventions may be required to ensure the person's safety. During our inspection visit we observed that this person was supported to access the community by a member of temporary agency staff who did not have training in physical intervention. The service manager explained the likelihood of the person requiring a physical intervention was low as the person was settled. However, they went on to tell us that the person's behaviours could escalate when their health condition fluctuated. We were informed that their health condition was fluctuating on the day of our inspection visit. Furthermore, we were also informed by staff that the person was currently in a period of heightened anxiety which could also impact upon their behaviour. Despite this there was no evidence that the risk of the person being supported by staff without physical intervention training had been considered. This failure to ensure that staff were sufficiently trained placed the person and staff at risk of harm.

Staff were not sufficiently trained to provide people with the treatment they may require should they injure themselves. During our inspection visit on 26 October 2017 we identified that only eight percent of staff had first aid training and this meant there were not first aid trained staff on shift at all times. This posed a specific risk to one person who was known to cause injury to themselves. This lack of first aid trained staff placed the person at risk of not receiving the immediate treatment they may require. We wrote to the provider asking them to take urgent action to address this issue. The provider informed us first aid training would be

delivered by 22 December 2017.This did not assure us that immediate action would be taken to mitigate the risks to people living at Orchard End. We discussed this with the provider on 16 November 2017 and they informed us that in the interim primary medical services would be utilized should someone require first aid treatment. This was not a safe or effective way of ensuring that people could access first aid treatment if needed. This ongoing lack of first aid trained staff placed people at continued risk of harm.

The above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA.

We saw there were some basic capacity assessments in place for routine areas such as personal care and medical appointments. However, people's capacity in relation to potentially restrictive practices had not been assessed. For example, one person was subject to continuous monitoring either through direct observation or over an audio monitor. This impacted on the person's right to privacy. Despite this, no capacity assessment had been conducted to assess whether or not the person had capacity. Consequently, there was no evidence that due consideration had been given to whether this level of monitoring was in the person's best interests. Another person had restricted access to certain drinks and again we saw that no formal assessment of their capacity had been conducted in relation to this decision. The service manager told us they were aware further improvements were required to ensure people's rights under the MCA were respected. They told us, "There will be gaps (in the application of the MCA)," and explained they were planning to start work on making improvements in the near future. However, work had not started in this area.

We wrote to the provider and asked them to take urgent action to address this. On 16 November 2017 we saw evidence that work had started on capacity assessments. However, we remained concerned about the competency of staff to recognise instances where people's rights under the Act were not being respected. For example, staff locked some foods away from one person. This had not been recognised as a restriction and consequently no capacity assessment had been conducted. This meant we could not be assured that people's rights under the MCA would be respected.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are 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 were being met. The service manager had made applications for DoLS where appropriate and some of these had been granted. There were no conditions stated on the DoLS we reviewed.

There was a risk that people may not always receive support with their health needs. This was reflected in feedback from relatives. The relative of one person told us they were concerned that staff may not notice if their relation became unwell as not all staff had an adequate understanding of how they communicated. During our inspection we found that whilst records demonstrated that people were given support to attend

appointments, care plans did not always contain sufficient detail about people's health needs and staff did not all have adequate training. Two people living at the home experienced seizures. One person's support plan had not been updated with the outcomes of appointments and consequently did not contain sufficient information about this health condition. For example, we saw a letter following an appointment with a specialist health professional in which it noted staff were not always identifying when the person's health deteriorated. The letter provided clear information about indicators of changes in the health condition, however the information had not been transferred in to the person's support plan. This posed a risk that changes in the person's health condition may not be identified. Furthermore, just over 50 percent of permanent staff had training about this health condition and the temporary agency staff we spoke with did not have any training. During our inspection we observed that one person was supported to access the community by a member of agency staff who did not have any training in the management of seizures. Staff rotas also showed that there were not always staff trained the management of seizures on night shifts. This failure to ensure staff had access to adequate guidance and training placed people at risk of not receiving the required support in the event of a seizure.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives of people living at Orchard End told us that they felt staff did not always have the required skills and competency to ensure safe and effective support. One relative told us the service was reliant upon them to train staff in some areas and another relative commented staff did not have adequate training to equip them with the skills to provide the specialist support required by people with autism. We also received feedback from a health and social care professional who commented that there had been an over-reliance upon external agencies to train and support staff. Feedback from staff was also mixed. Whilst one member of staff told us they had enough training, another member of staff told said they felt the online training they received was not sufficient and said "I would like more training in all areas." Training records showed improvements were required to ensure that all staff had the required training.

New staff were provided with an induction period when starting work at the service. The service manager told us that staff induction included training and shadowing of more experienced staff. New staff were also in the process of completing the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Staff told us that they felt supported and records showed they had received regular supervision. Staff also told us they offered support following after potentially stressful events.

Feedback from people's relatives about food, drink, diet and mealtimes was mixed. A relative told us the staff team had previously been good at promoting healthy and varied alternatives to their relation. However, they told us this had "dropped" recently and they felt that this was due to changes in the staff team. We also received negative feedback from another relative about the quality and variety of food offered at Orchard End. During our inspection we found that people had enough to eat and drink. Staff told us that people chose what they ate on a daily basis and our observations confirmed this. Where people had risks associated with their diet these had been identified and recorded in their care plan and staff had an understanding of how to support people in this area. For example, one person had a condition which required them to have a specific diet and regular monitoring. During our inspection visit, we observed staff prompting the person with their diet and supporting the person to perform their own monitoring. Where people were at risk of losing weight this was monitored and action taken to address any unplanned changes.

Requires Improvement

Is the service caring?

Our findings

Feedback about the impact of the support people received at the service was poor. Two of the relatives we spoke with told us that they believed that their relations were not happy at Orchard End. Another person living at the home told us they were not happy and wanted to move on, they told us the staff were 'alright' but said they wanted more freedom.

Due to staffing issues there was a lack of continuity of staff and consequently staff were not always familiar with the person they were caring for. Throughout our inspection the quality of interactions between people who used the service and staff were variable. The culture was not person centred and the kind and compassionate care we observed was due to the skill and effort of individual members of staff. Some staff clearly knew people well, understood what mattered to them and used this to inform their support. These staff were kind, caring and friendly in their approach. Other staff did not have a good understanding of each individual and the interactions with people living at the home were functional and task focused. We observed some staff spent significant amounts of time observing and supervising people and did not try to engage people in meaningful activity. Our observations were supported by feedback from people's relatives who told us the quality and consistency of support varied depending upon the staff members on shift. This meant that people could not be assured that people would receive person centred support that was based upon their individual needs and preferences.

People were not always supported to maximise their independence. This was reflected in feedback from people's relatives. One relative explained they thought staff did too much for their relation and could do more to promote their independence. Another relative told us although some staff attempted to promote their relation's independence with domestic duties, this was not successful as staff did not have a good understanding of how to support them and so often just "left them to it". The relative felt this led to the person becoming anxious. A third person living at the home had expressed a preference to become more independent. Although staff were able to tell us about some tasks, such as domestic chores, that the person completed independently there were no written plans in place detailing how staff should support the person to develop their skills and achieve their goals. We spoke with the service manager who told us they were working with the person's social worker to find alternative accommodation. However they confirmed there were no written plans about how staff should support the person towards specific goals. For example, we asked if the person was able to manage their own medicines, the service manager told us they could "probably" work towards this but confirmed there were no plans in place in relation to this. This meant the service was not effectively promoting people's independence.

Communication with people with complex needs was inconsistent. Although we saw that people's support plans contained information about how they communicated, staff did not always have a good understanding of this. People's relative's told us changes within the staff team and the use of temporary agency staff meant that some staff had a limited understanding of how people communicated. They explained that this had resulted in staff missing subtle changes in people's behaviours which were indicative of their mood and wellbeing.

People's relatives also told us that some staff did not have an adequate understanding of autism and the associated anxieties experienced by people. One relative told us told us they felt that, although not intentionally, staff actions sometimes triggered people's behaviours. Another relative shared an example, where, due to a lack of understanding of what mattered to the person, staff actions had led to the person becoming distressed and requiring staff to intervene. This was also reflected in our discussions with a staff member, who explained that not all staff were fully aware of triggers to people's anxieties and behaviour. Training records showed staff had attended an online 'autism awareness' course and some staff had positive behaviour support training. However, there were no records to demonstrate staff had any specialist training in autism or communication.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People's privacy was not always respected. One person was subject to continuous visual or audio monitoring. During our inspection visit we observed an agency staff member walking around the home with an audio monitor turned up whilst the person was having private time in their room. This did not respect their privacy. We discussed this with staff and the service manager who explained that, as other safety equipment was currently out of use, audio monitoring was the only way to ensure the person's safety. However, we remained concerned that audio monitors were not being used as discreetly as possible. Despite this people and their relatives told us staff respected their right to privacy. One person who lived at the home told us "I get private time and staff always knock." The relative of another person told us, "Yes (staff do respect relation's privacy) as far as possible." In other areas we observed that people's privacy was respected. Staff knocked on people's doors before entering and prompted people to attend to their own care needs as required. Staff respected people's right to confidentiality. Conversations about people's support needs were held in areas that could not be overheard and care records were stored securely.

People who used the service were supported to be involved in their care and support. Regular one to one meetings were held for people who used the service. We saw records of these meetings which showed that they were used to discuss topic such as their wellbeing, activities and food.

People had access to an independent advocate if they wished to use one to help express themselves. Advocates are trained professionals who support, enable and empower people to speak up. No one was using one at the time of our inspection. Although we observed there was information about advocacy displayed in the service this was not in a format that was accessible to people who used the service, therefore people were reliant upon staff to make them aware of advocacy services.

Requires Improvement

Is the service responsive?

Our findings

People could not be assured that their concerns or complaints would be managed sensitively or effectively. People's relatives told us they did not have confidence in the provider to handle complaints effectively. They shared examples where they had raised concerns with the provider and felt these had not been responded to or addressed sufficiently. We spoke with one person who told us they had asked staff to record complaints on their behalf. They told us they felt nothing was done about their complaints and said they felt ignored. We reviewed complaints records and found none of these complaints had been recorded or handled using the formal complaints procedure. This meant people living at the home could not be assured that their complaints would be handled in a fair and equal manner. We found that other complaints and concerns, for instance from members of the local community had been recorded and addressed in accordance with the provider's complaints policy.

People were at risk of receiving inconsistent support. Each person who used the service had an individual support plan; however the quality of these was variable. Whilst some support plans were detailed and personalised others lacked detailed information and had not been updated to accurately reflect people's needs. For example, one person had specific support needs related to how they expressed themselves. Staff we spoke with had an understanding of this but there was no information about what support the person required or how to talk to the person about their needs in their support plan. Other support plans had not been updated to reflect learning from adverse incidents so did not detail how best to support people to ensure their safety. These deficiencies in support plans placed people at risk of not getting the support they required.

The above risk was exacerbated by high usage of temporary agency staff. The agency staff we spoke with told us they had read people's support plans "briefly." We observed people's care plans were long and complex. There was no clear and succinct information for temporary staff to quickly gain an understanding of what mattered to people and how to keep them safe. A member of permanent staff told us that agency staff did not always have time to read support plans and instead supported people based upon verbal information given by staff. This meant people may be exposed to inconsistent support which did not meet their needs.

The service manager told us they had identified support plans as an area for development when they started at the service. They were in the process of developing and updating all care plans. They told us people's families were involved in the update of support plans and they were also encouraging staff to have an input. The provider also informed us support plans would be reviewed to ensure important information was easily accessible to all staff.

People were not always provided with the opportunity for meaningful activity. People and their relatives told us they or their relations did not always have enough to do with their time. One relative explained activities did not always take place as planned as there were not always enough trained staff available to safely support their relation in the community or to drive the vehicle. This was confirmed by our inspection findings. The service manager explained activities were personalised to each individual's preferences. We

saw that one person had an activity planner. Staff told us that they tried to stick to this but it depended upon the person's mood and staff availability. This was confirmed by records which documented occasions where planned activities were not able to go ahead due to a lack of drivers or where the use of agency staff prevented this. The other person living at the home did not have an activities plan in place and staff told us they had little structure or routine to their time. A member of staff told us they felt this person was sometimes 'overlooked' and the person themselves told us they often felt bored. They told us, "I get bored sometimes, I pace up and down." This meant we were not assured people's social needs were met.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Throughout our inspection of Orchard End we identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, staffing, safeguarding people from abuse and improper treatment and the implementation of the Mental Capacity Act 2005. This led to multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was the first inspection since Orchard End was registered to provide a regulated service. However, many of the concerns identified at Orchard End were similar to concerns found at recent inspections at other locations operated by the provider. It is therefore of concern that a number of serious risks to the health and safety of people living at Orchard End had not been identified and addressed by the provider prior to our inspection based upon past experience.

The provider did not have an effective system in place to review and analyse incidents and other significant documentation, such as body maps and behaviour charts. The service manager told us there was no system in place to review and analyse charts used to record behavioural incidents including those where people caused injury to themselves. This meant that opportunities to learn about potential triggers for people's behaviours may have been missed. The service manager told us that incident records were reviewed weekly. However, we found that although the majority of incident records had been reviewed by a team leader none had been reviewed by the service manager to ensure appropriate action had been taken. We saw that this had resulted in key information not being incorporated into support plans and a consequent lack of information for staff. Although we saw some action had been taken to address issues arising from some incidents this was down to the skills and competency of individual staff members rather than being driven by effective systems and management. This exposed people to the risk of potential harm and injury. We wrote to the provider and asked them to take action to address this issue. They informed us systems were being implemented to ensure that incidents were analysed and investigated. We will check the impact of this at our next inspection.

The provider had not ensured that staff employed at Orchard End had sufficient skill or knowledge and had not provided adequate guidance for them to be able to deliver their vision of 'high quality residential care and support for people with an Autistic Spectrum Disorder and additional severe and complex needs.' This was reflected in comments from people's families. Relatives told us they did not have confidence in the provider. One relative explained that they chose Orchard End because of the ethos of the provider, they went on to tell us they felt this ethos of personalised, high quality care had deteriorated over recent months. Although staff had received online autism awareness training the findings of our inspection demonstrate that this did not provide them with sufficient knowledge or skill to enable them to provide specialist support. Staff did not always have the necessary skills or knowledge to meet people's health needs or ensure their rights were adequately protected. In addition to this we received feedback from external health professionals that there had been an over reliance upon external resources to deliver specialist aspects of service and ensure staff competency. This failure to ensure specialist support to people has had a negative impact on people living at the home.

Systems in place to monitor and improve the quality of the service were not always comprehensive or effective. The provider had some processes in place to monitor the quality and safety of the service and checks were completed on a regular basis including the safety of the environment, medicines management, care records, staffing and training. A representative of the provider had also recently completed an audit of the home. We saw these systems had identified some, but not all issues identified during our inspection. For example, we reviewed recent medicines audits undertaken by staff and found that the issues identified during our inspection were not found at any of these audits. Furthermore, we found where issues had been identified, swift action had not been taken to address these to ensure the safety of people living at Orchard End. For example, the service manager had an action plan in place which identified the need for staff to attend first aid training. The target date for completion was 11 September 2017. During our inspection we found 92 percent of staff still did not have training in first aid. This failure to take action on issues exposed people to the risk of harm.

Action had not always been taken in response to concerns raised in audits conducted by external agencies. During our inspection visit we reviewed the findings of an audit conducted in May 2017 by the local authority. This had identified some concerns in relation to care planning and risk assessment. No action plan had been developed in response to the findings of the audit. Consequently during our inspection we found continued concerns in relation to the areas identified in the audit. For example the audit found that care plans did not contain sufficient detail about one person's diverse needs and during our inspection we found that this continued to be an issue.

People's families told us communication between themselves, the service and the provider was poor. One person's relative told us, "Communication is not very good. They don't tell us much. They didn't tell us when [relation] went into hospital." Another relative commented "We don't get much information, I constantly have to go to them for updates." Families told us they did not feel involved in the running of the home and also commented they were not kept up to date about changes within the organisation. One relative told us, "We get no formal communication about changes in the company, it is all gossip and what we hear on the grapevine." There had been no recent meetings for families of people living at Orchard End.

The provider had not ensured the service manager had a sufficient induction to their role and this impacted upon their ability to ensure the safe and effective running of the home. People's families and staff told us the service manager had been "left to get on with things" which had resulted in them being "bogged down" and "firefighting". At the time of our inspection visit, the service manager had been in post for approximately two months, however they had only had limited online training in this period. They told us other training had been planned for them but "things had come up at the service which had prevented them from attending". This had resulted in the service manager not having had important training such as training to provide them with the skills to manage and oversee the safe administration of medicines. We wrote to the provider and asked them to take action to address this issue. They informed us the service manager would be provided with a full induction. The provider also informed us they were making improvements to the senior management structure which would ensure managers of services were better supported. We will check the impact of this at our next inspection.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the provider had not ensured that we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of a safeguarding incident with was reported to the local authority. They had also failed to inform us of any Deprivation of Liberty Safeguards (DoLS) authorisations (a safeguard to ensure that the freedom of people living in care homes is

not unnecessarily restricted). A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was no registered manager in post at the time of our inspection, the previous registered manager had left the service in July 2017. The service manager had been in post since August 2017, however they were not registered with CQC. We spoke with the provider about this who told us they would ensure a manager was registered with CQC to oversee the running of the service. We will monitor this.

Despite the above information the service manager told us they felt supported by the provider. They told us senior members of the team had provided support at particularly challenging times. They also added that the provider ensured they had the resources they needed. For instance, they had recently requested a laptop for staff training and this had been provided. The service manager explained that they kept up to date with best practice in a number of ways, including; linking with other local registered managers employed by the provider and by conducting internet research. Staff were positive about the service manager and felt they had a positive impact on the service. One member of staff told us, "[Service manager] is easy to talk to and has made changes. I feel like they have a vision for the service." Another member of staff commented, "I think [service manager] has had a positive impact, they are firm but fair."

Staff were given an opportunity to have a say about the service in regular staff meetings. Records of these meetings showed that they were used to share good practice, discuss concerns and discuss the care and support of people living at the home. Staff told us they felt able to make suggestions about the service and said the service manager acted upon their suggestions.

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 18 Registration Regulations 2009 Notifications of other incidents Notifications of safeguarding concerns and authorisations of DoLS were not submitted to the Commission as required. 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with person centred care which met their need and preferences. Regulation 9 (1)

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 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act 2005 were not respected. Regulation 11 (1)

The enforcement action we took:

We imposed conditions on the location's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected from the risks associated with their care and incidents were not analysed to reduce risk of recurrence. Regulation 12 (1) (2)

The enforcement action we took:

We imposed conditions on the location's registration.

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 Appropriate action was not taken to ensure that people were protected from abuse and improper treatment. Regulation 13 (1)

The enforcement action we took:

We imposed conditions on the location's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Systems in place to monitor and improve the quality and safety of the service were not effective. Action was not taken in response to know concerns. Appropriate action was not taken to investigate incidents which posed a risk to the health and wellbeing of people who used the service. 17 (1)

The enforcement action we took:

We imposed conditions on the location's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough adequately trained staff to provide safe care and treatment. Regulation 18 (1)

The enforcement action we took:

We imposed conditions on the location's registration.