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Bedrock Mews - New Road

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bedrock Mews provides accommodation and personal care for up to six people aged 18 years and over. At the time of our inspection five people were using the service.

This inspection was unannounced and took place on 15 and 16 February 2017.

We carried out inspections of three of the provider's locations from 13 to 17 February 2017. These locations are; Bedrock Lodge, Bedrock Mews and Bedrock Court. The reports of all three inspections can be viewed on our website. The provider's main offices are at Bedrock Lodge. We found many aspects of the service provided at the locations to be similar. This is because the policies, procedures, systems and processes used by the provider were consistent across all three locations. In addition, a number of staff worked across all three locations and, until recently the service users from each location attended Bedrock lodge during the day. As a result, each of the three reports contains some information that is similar.

Our last comprehensive inspection of this service was carried out in June 2015. At that time we rated the service overall as 'Good'.

As a result of concerns shared with us, we carried out a focussed inspection of Bedrock Mews in September 2016. At that time we rated the service as 'Inadequate' under the three key questions we looked at. These were; is it safe, is it effective and is it well-led? We were unable to change the overall rating for the service following that inspection because it was not a full comprehensive inspection and, was carried out more than six months after our previous inspection.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager resigned from the provider's employment over 18 months ago. Despite assurances from the provider that they were going to employ a registered manager the provider had failed to register a manager with the CQC. The provider had taken responsibility for managing Bedrock Mews. The provider who took the lead in matters concerning the care and support provided was not available when we visited.

Following our previous inspection, the provider had made arrangements for a 'turnaround team' to oversee the management of the service. This had involved the provider commissioning experienced health and social care staff to be available on a day-to-day basis and co-ordinate the management of the service. At the time of our inspection, the provider's three services were managed by an independent project manager, they oversaw the senior person from the 'turnaround team' and an acting manager directly employed by the provider, who managed an assistant manager, senior care staff and support workers.

After the inspection in September 2016 some improvements had been made to ensure that people's

immediate safety was considered and action taken. Immediate actions included, investigating the possibilities of finding alternative placements for people whose needs were not being met and people not being required to attend another of the provider's locations for day care.

During this inspection, improvements were identified and are referred to throughout this report. However we were concerned the improvements we saw would not be sustained following any withdrawal of the 'turnaround team'. Staff employed directly by the provider and, members of the 'turnaround team' themselves were unclear how much longer this arrangement would be in place. We wrote to the provider and told them to provide us with further information detailing their plans for any withdrawal of this additional input. The answers we were given were vague and they told us a date for withdrawal had not been identified and that plans were yet to be agreed. This raises concerns and, we could not be satisfied, that the improvements we found would be sustained and that subsequent improvements required would be achieved.

Staff told us they were concerned any improvements would be reversed when the 'turnaround team' were no longer in charge and the provider took control. Some senior staff told us they felt they were able to withstand attempts to do this; others felt it unlikely they would be able to do so.

Since the inspection in September 2016, there had been 11 new individual safeguarding concerns raised with the local authority relating to people living at Bedrock Mews and 35 in total across all three of the provider's locations. The concerns about the service were still considered a risk by the local authority and other agencies, and the service continues to be placed in an organisational safeguarding process.

Staff still lacked the skills and abilities to provide effective care and support. Staff did not always have a good understanding of the principles of the Mental Capacity Act (MCA) 2005 or best interest decision making. However, people told us they were now able to make more day-to-day choices and decisions. Relevant health and social care professionals were now more involved in ensuring people's needs were met.

At the inspection in September 2016 we found the provider and staff had failed to recognise where certain practices compromised people's dignity and respect. We also reported that the service was, in many ways, demeaning to people and did not contribute towards them being viewed as valued individuals. The improvements made had been led by the 'turnaround team'. People told us they felt they were better cared for and more able to exercise their independence. However further progress will be required to take this forward as the structure and delivery of the service is still more likely to foster dependence than independence, because of the way the service has been previously led and managed.

People still gave the impression of feeling they were required to fit into the service rather than the service being designed and delivered around their needs. In addition, the service had failed to continually assess and support people in ensuring the service was still a suitable place for people to live. The provider had failed in their responsibility to engage with commissioners who funded people's placements to ensure that placements were still appropriate. The impact on people due to the lack of support and planning to ensure smooth transitions was unsatisfactory. The attitude of staff to other professionals was not always positive. They did not see the professionals' support as helpful and in people's best interests. Although the 'turnaround team' had tried to change this attitude, it was still evident with some staff.

Although staff were making efforts to provide activities that were person centred and supported choice and personal preferences, their attempts were compromised by the provider, and this reinforced our previous concerns around the control they exercised.

Since the 'turnaround team' commenced in November 2016 they had needed to prioritise the most urgent areas for improvement in order to keep people safe. Some of the actions they had taken had improved the quality of service people received. This was particularly around improving their day to day lifestyle. People were making far more choices about everyday matters, for example, what time they got up, when they went to bed, what they did during the day, what they ate and drank and when they received meals. They had worked extensively with permanent staff members on role modelling, coaching and introducing best practice.

People told us they felt safer. Staff had a better understanding of how to recognise the possibility of abuse and report concerns appropriately. Staffing levels had increased. The management of medicines had improved and people benefitted from revised individual protocols for the administration of these. Staff had received some additional training to meet people's needs. We saw staff treating people in a more caring manner. People's care records were written in a more objective and positive manner. The turnaround team had tried to build better working relationships with other agencies and to educate staff on the importance of this in order to enhance people's health and well-being.

Following this comprehensive inspection, the overall rating for this provider is 'Inadequate'. This means it has been placed in 'special measures'. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Full information about CQC's regulatory response to these concerns will be added to reports after any representations and appeals have been concluded.

We found and, have reported on, breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in our report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had a better understanding of how to recognise the possibility of abuse and report concerns appropriately. However, the provider had not built confidence and trust with the local authority. We cannot be satisfied in the ability of the provider to improve relationships in addition to being able to sustain this in the long term and ensure people are kept safe.

Risk assessments had been revised and provided staff with guidance on keeping people safe.

People said they felt safer now the service no longer operated as the base for people from the provider's other locations during the day.

The management of medicines had improved and people benefitted from revised individual protocols for the administration of these.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received some additional training to meet people's needs. However, staff still lacked some skills and abilities to provide effective care and support.

The service provided was not always in accordance with the principles of the Mental Capacity Act 2005 (MCA).

People were now able to make more day-to-day choices and decisions. They had access to hot drinks or snacks when they wanted them and, were able to choose activities they wanted to do and food they wanted.

Is the service caring?

Requires Improvement

The service was not always consistently caring.

Staff treated people in a more caring manner and care records

were written in a more objective and positive way.

However, overall the structure and delivery of the service fostered dependence rather than independence.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs, wishes and aspirations were not brought together in a plan aimed to meet these. People's views and opinions were not always sought when planning their care and support.

The provider had not always worked in co-operation with other health and social care professionals to ensure these moves were as smooth as possible for people.

People had greater freedom over choosing what they did during the day.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

The culture of the service was not empowering and person centred.

There was no clear plan for the withdrawal of the 'turnaround team', sustaining improvements or, the provider's plans for the future of the service.

Bedrock Mews - New Road

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 February 2017 and was unannounced. This meant the provider did not know we would be visiting.

The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of services for people with long term mental health needs

The last full inspection of the service was carried out in June 2015. At that time we did not have any concerns and rated the service overall as 'Good'. As a result of concerns shared with us and, the provider being placed in 'organisational safeguarding' by the local authority, we carried out a focussed inspection of the service on 29 September 2016. At that time we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated the service as 'Inadequate' in the three key question areas we looked at.

Prior to this inspection we looked at the information we had about the service. This included information of concern shared with us by health and social care professionals. We also reviewed the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Due to the number of individual safeguarding concerns raised regarding the provider's services. This location (along with two others managed by the provider) had been under a process of 'organisational safeguarding'. This is a process initiated by the local authority as a result of the number and/or severity of concerns raised with them. CQC had attended several meetings prior to this inspection. This meant CQC had been closely involved with a number of health and social care professionals, social workers and

commissioners regarding the service. We have referred to the intelligence reports we have received from those that visit the service and from multi-agency meetings we have attended.

During the inspection we spoke with each person people living at Bedrock Mews. We also spoke with a total of five staff. This included; the acting manager, members of the 'turnaround team' and support workers.

We looked at the care records of four people living at the service, staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People did not always receive a service that was safe.

At the inspection in September 2016 we found people were at considerable risk. A substantial number of risks were immediately reduced following the inspection. This was attributed to, investigating alternative placements for people whose needs were not being met at the service and people not being expected en-masse to attend day care at another of the provider's locations. Despite some improvements and positive responses from people around feeling safer, a number of concerns and breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 still remain. In addition there had been 11 new individual safeguarding concerns raised with the local authority about Bedrock Mews from 1 October 2016.

During our inspection in September 2016, we received concerning responses from people regarding whether they felt safe. These had been referred due to the local authority as safeguarding alerts and investigated with action then taken to keep people safe. At this inspection people said they felt safe at Bedrock Mews. Comments included; "Yes, I generally feel safe here", "Yes I'm OK, I've seen the changes and they're good" and, "It's changed for the better, changed a lot since you were last here. I think it's safer".

At the inspection in September 2016 we found people were not kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. We also reported the provider had not always raised concerns immediately with the appropriate authorities. Since the September 2016 inspection, staff had received additional training on safeguarding and protecting vulnerable adults. They were now able to tell us what action they would take if they suspected, witnessed or received allegations of abuse.

There had been a significant amount of safeguarding concerns raised to the local authority, police and CQC following the inspection in September 2016. These had been managed through the local authority's individual safeguarding processes and some were still being investigated at the time of this inspection. Although staff had raised some safeguarding concerns, many had resulted from the increased involvement from other health and social care professionals visiting the service. We noted the improvements in managing safeguarding processes had been led by the 'turnaround team'. Permanent staff told us they felt the provider had not tried to build and maintain confidence and trust with the local authority. They had found this to be a continued barrier and in a sense felt that ongoing relationships and effective communication was difficult with the local authority. Considering these factors we cannot be satisfied in the ability of the provider to improve relationships in addition to being able to sustain this in the long term and ensure people are kept safe.

These were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

At the inspection in September 2016 we found risk assessments were not always in place to keep people staff. Where they were, they lacked detail for staff to follow. Assessments did not result in clear plans to keep

people safe. Guidance for staff was not clear. Staff were not always familiar with the content of any assessments and plans that were in place. We saw improvements had been made with individual risk assessment and management. Individual risk assessments and management plans had been revised and now gave guidance for staff on how to support people when anxious and distressed. Some of these were rather basic and lacked detail. Senior staff said they were aware these needed further development. Staff were not always clear about the content of individual risk assessments and management plans but were aware of where to find them. This requires improvement to ensure people are kept safe.

Following our inspection the provider sent details of training undertaken by staff regarding infection control. They also provided evidence of infection control audits that had been completed. Measures to prevent and control the risk of infection were in place.

People were supported by sufficient numbers of staff to meet their needs. People said they were able to receive care and support from staff when they needed it. During our visit we saw there were enough staff to safely provide care and support to people.

At the inspection of September 2016 we found people's safety was compromised because apprentices were expected to carry out the full range of duties expected from other permanent care staff. We further found that, considering people's diverse and complex needs apprentices did not have the qualifications, competence, skills or experience for the work they were expected to perform. During this inspection staff and, apprentices themselves, told us this was no longer the case. They said apprentices were no longer providing personal care unsupervised. Staff rotas showed apprentices were additional to the usual staffing levels as would be appropriate for their level of experience.

The recording of the administration of medicines had improved. Records were kept detailing when as required ('prn') medicines had been administered. These recorded how people presented before and after the administration of medicines for anxiety and distress. Staff were able to explain to us the process for administering these medicines. Individual protocols were in place to guide staff on when and how to offer these medicines.

Requires Improvement

Is the service effective?

Our findings

People did not always receive a service that was effective in meeting their needs.

At the inspection in September 2016 we found the service was not effective in meeting people's needs. This was particularly in relation to the skills, abilities and knowledge of staff, the provider and staff not supporting people to make choices and decisions and, the provider not complying with the requirements of the Mental Capacity Act 2005 (MCA). Whilst we noted some improvement at this inspection, people were still not receiving a service that consistently met their needs.

Observing staff practice and talking with them and with members of the 'turnaround team' it was evident that further improvements around staff training were still required.

This was because staff still lacked the skills and abilities to meet people's needs with regards to their mental health. Staff had not all received training on relevant mental health conditions. Staff said they still felt further training in these areas would help them to better respond when people were anxious. Some people needed support to manage their behaviours. Through observing and speaking with staff it was apparent they still lacked knowledge in how to provide the support people required. The only reason why the risks this posed had decreased was the involvement of the 'turnaround team'. They had been able to provide advice and guidance when required. The provider had not taken action to ensure staff had the skills, abilities and knowledge to meet each person's needs. One person spoke with us about their experience of their mental health condition. They said staff lacked the knowledge and insight to help them when needed.

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

Staff also lacked understanding of person centred approaches to care. This was recognised by staff, managers and the 'turnaround team'. Staff said the 'turnaround team' had helped them by providing role modelling and coaching but felt they needed further training.

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

At the inspection in September 2016 we found the provider/ manager and staff did not understand the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

At this inspection we found some improvements had been made. Mental capacity assessments had been completed for people and we saw examples of best interest decision making in accordance with the principles of the MCA. However, although staff had received further training following the inspection of September 2016, we found they still did not always have a clear understanding of the principles of the MCA or best interest decision making.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for Consent.

At our inspection in September 2016 we found a number of DoLS applications that had been submitted for other people were not authorised and returned by the authority(s) because those people had the mental capacity to make the decision themselves. This showed the provider and staff lacked an understanding of the DoLS process. The 'turnaround team' had taken responsibility for managing DoLS applications and we saw this had improved. A system was in place to track progress on applications and monitor when authorisations had been granted and would lapse. They had also introduced a process for monitoring consultation regarding DoLS authorisations with people's recognised person's representative (RPR).

At the inspection in September 2016, involvement from relevant health and social care professionals had not always been sought. Health and social care professionals told us they felt the provider did not seek their assistance and staff were sometimes resistant to support and provide guidance. Some improvements had been made and people were benefitting from more involvement with relevant professionals. However, feedback from professionals continued to be mixed. Some reported staff had not always been helpful in ensuring people were available for appointments they had made. Others had noted improvements in the service provided, with some positive feedback given on the work done by the 'turnaround team'. However, many expressed concern the improvements made would not be sustained by the provider.

At the time of our last inspection people had been registered at the same surgery as people using the provider's other services. This surgery was not local to them. The appropriateness of this arrangement had been questioned at a multi-organisational safeguarding meeting. Historical concerns regarding the ability of staff to respond to medical emergencies also contributed to questioning this arrangement. The provider had been instructed to alter this. People had now registered with a GP practice closer to their home. This meant it would be easier for them to receive home visits if required and, easier for them to get to the surgery.

At the inspection in September 2016 people did not have access to hot drinks or snacks when they wanted them. They were not empowered to make choices about what they ate each day and kitchen doors were routinely kept locked. Since the inspection, people told us they had more choice over what they had to eat and drink. They said, "And the choice of food has got a lot better, with a good choice", "Now we have a choice of menu for our lunch and our supper, which before (Provider's name) gave us what she thought we should have; and no choice. It definitely has changed for the better since you were here", "We get a good choice of food now. My favourite meal is roast dinner" and, "I don't cook. But I can go into the kitchen now. Which is unsupervised. Which is much better and I can make a cup of tea as and when I need to". Staff told us people are now able to access the kitchen when they want to. One staff member said, "I used to steal food from Bedrock Lodge (the provider's location, people used to attend for their day service activities) to bring back to the Mews as there was no food there". This person told us the changes had been positive but doubted they would be maintained by the provider when the 'turnaround team' left.

At the inspection in September 2016 we could not be satisfied that staff supervision and support was effective because of the concerns we had identified during our visits. Staff felt this had improved in recent months, they felt better supported on a daily basis and their individual supervision sessions were more

effective. Supervision is a one-to-one meeting a staff member has with their supervisor to discuss their performance, share concerns and measure their progress. Supervision records were brief but did contain details of conversations with staff on how they could improve their performance in providing care and support.

Requires Improvement

Is the service caring?

Our findings

People did not always receive a service that was consistently caring.

Staff we spoke with felt improvements had been made in providing a caring service. They acknowledged a person centred approach and ethos had been promoted and led by the 'turnaround team' and that additional training and support would help with further improvements. Many expressed concern that these changes would not be fully supported when the 'turnaround team' were no longer in charge and the provider took control. Staff reported that in the absence of the provider, and with the support of the 'turnaround team', they felt more valued, empowered and 'liberated'. This had a positive impact on their well-being and as a result the care and support they provided to people.

People told us they received a more caring service. We saw staff talking to people in a caring manner. The expert by experience commented that staff seemed 'more relaxed with the residents' than when they last visited.

At our last inspection in September 2016 we found the culture of the service did not promote dignity and respect. People had little choice over what they did during the day. They were expected to attend a day service at Bedrock Lodge. People were expected to conform to 'house rules'. These detailed when they were expected to go to bed and eat meals. Mr. Men characters were displayed on people's doors. These were childlike and potentially insulting.

During this inspection we found improvements had been made and people now had greater control over their day-to-day routines. Comments from people included, ""I think I really like being able to go over to the shops and buy my own tobacco without staff supervision", "This is now my home and I prefer not going over to the lodge, it was boring just sitting there with no activities" and, "We also don't have to go to the day centre at the Lodge, which was boring. And if I didn't get up in time to go to the lodge, I got locked in the house until they came back at 4pm. That's changed now". It's much better being at home and doing things than going down to Bedrock Lodge every day" and, "I like being here during the day and doing things", "We can go into the kitchen more now" and "There is more freedom". We saw staff had removed the Mr. Men characters from people's doors and 'house rules' were no longer used.

Some care plans had been rewritten and now gave a better overview of people. Most people using the service would, with some individualised support, have had the skills and abilities to help develop their plans. This would have shown people's views and opinions were respected and that they were valued as individuals. There was little regard paid to ensuring people had clear goals based upon their needs, wishes and aspirations. Care planning although more thorough than when we previously inspected remained functional, rather than developmental and aspirational.

Staff had still not received training on equality and diversity. Staff we spoke with did not have an understanding of their role in ensuring people's equality and diversity needs were met. Care plans did not assess people's needs with regards to equality and diversity. There was no appreciation of people's cultural

or religious backgrounds, sexual orientation or any other relevant protected characteristic as defined in the Equality Act 2010. This requires improvement to ensure staff value people and afford them with dignity and respect.

Through talking with people, staff and the 'turnaround team' it was apparent they felt there had been many positive improvements to the service provided. However, many expressed concerns these positive changes would be reversed when the 'turnaround team' were no longer in charge and the provider took control.

Inadequate

Is the service responsive?

Our findings

People did not receive a service that was responsive to their individual needs.

Although we noted improvements in the service provided to people, it was still not responsive to their individual needs. People told us of feeling they were required to fit into the service rather than the service being designed and delivered around their needs. In addition the service had failed to continually assess and support people in ensuring the service was still a suitable place for people to live. It was evident at the inspection in September 2016 the service was not meeting people's needs. They had also not encouraged people to develop and learn new skills so that they could live in a more independent setting. The provider had failed in their responsibility to engage with commissioners who funded people's placements to ensure that placements were still appropriate. These opportunities had been missed. There was little forward planning to help people identify how their needs, wishes and aspirations could be best met.

As a result of the inspection in September 2016 health and social care professionals had a responsibility to re-assess placements due to the concerns we raised. One person had arrangements in place to move the week after this inspection. They very clearly stated the service had provided them with some stability but felt they needed to move to more independent living. When speaking with us they shared concerns regarding not being kept up to date with progress on finding alternative living and care arrangements. Health and social care professionals had reported to us that communication with the service was not always good. This was very concerning as people were clearly concerned about their future. The provider had not ensured staff worked effectively to ensure their concerns were recognised and clear plans agreed with people to manage any planned transitions.

At our last inspection in September 2016 we found records of the care and support people received were not accurately maintained. Care plans were not sufficiently detailed or written in a person centred manner. Information was not always accurate or relevant. Daily records were often written in a negative and judgemental manner. These gave the impression of unequal relationships between people and staff and, a lack of respect for people.

During this inspection we found improvements had been made. Care plans were now kept up to date and were more detailed. Language and terminology was not as negative and judgemental as before.

However, the service as a whole was still not built around people's individual needs with care planning, the routines within the service and staff approach to people, all contributing towards dependence rather than independence being fostered.

People said they had not been involved in agreeing their care plans. Senior staff told us they had been involved in developing them. Some care plans contained statements that people had been involved in writing them others did not. Care plans still contained lots of information about what people could not do, with little identified to help them learn, develop and grow. A consequence of this meant that some people who had used the service for a long time had become deskilled. They did not give a clear picture of people's

life history, likes and dislikes or hobbies and interests. Where people required support to assist them to manage their behaviour some plans were in place. However, suitable measures were not always available for staff to support people in a sensitive, caring manner when people exhibited these behaviours. This meant the root cause of people's behaviour was not addressed but was often exacerbated.

These were continued breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

At the inspection in September 2016 there was little or no choice about the type of activity most people did during the day. They either attended 'day care' at one of the provider's other locations or planned community activity en-masse. Improvements had been made and activities were now being planned with people. Senior staff told us activities were now based on people's hobbies and interests. One member of staff made a comment that this would not have happened if it wasn't for the inspection that took place in September 2016. However we do have concerns that staff will be prevented from continuing with this when the 'turnaround team' were no longer in charge and the provider takes back control. We were informed during our inspection, of an incident where the provider had requested an activity was cancelled due to cost. This activity had been previously requested and enjoyed on several recent occasions by people. The trip involved a car journey to a local service station to enjoy a hot chocolate drink. The turnaround team and staff acknowledged this compromised their attempts to provide person centred activities chosen by people and, reinforced our previous concerns around control exercised by the provider.

We spoke with a staff member who had recently been appointed as activities organiser. We understood this staff member was initially concentrating on organising activities at one of the provider's other locations, following which they would assist with doing so at Bedrock Mews. We found they were very enthusiastic and had a number of ideas they wished to explore with people and it was encouraging to meet with them.

We recommend that the service seek advice and guidance from a reputable source, about providing meaningful activities and stimulation for people so they are suitably equipped for their role.

At the inspection in September 2016 we found that complaints were not managed effectively. A system for managing complaints was now in place. Meetings were held for people to express their views. These had been led by the 'turnaround team' and easy read minutes were produced. Care had been taken to find out how people felt and discuss changes made and planned.

Since the inspection in September 2016 staff had met with people and families to explain the findings of our report and its potential implications. Feedback on these meetings had been mixed. Some people had found them helpful; others said it had caused them to worry more. Some relatives had attended meetings; others had not received invitations in time to come. This must be improved to ensure staff keep people and relatives fully informed on changes that affect them.

Inadequate

Is the service well-led?

Our findings

People did not benefit from a service that was well led.

A condition of the provider's registration is to ensure the regulated activity of accommodation for persons who require nursing or personal care is managed by an individual who is registered as a manager in respect of the activity. Bedrock Mews has been without a registered manager since July 2015. Despite requests to do so, the provider had not ensured a registered manager was in place. The provider had taken responsibility for managing Bedrock Mews in the absence of a registered manager.

This was a breach of Section 33 of the Health and Social Care Act 2008.

Since the inspection in September 2016 the vision and values of the service remained unclear. Although the provider had appointed the 'turnaround team' following the inspection in 2016 we were unable to see how the improvements made would be sustained if the team were to leave. We wrote to the provider following under Section 64 of the Health and Social Care Act 2008. We asked when the 'turnaround team' would be withdrawing, the plans to manage this and the strategy for managing the service once they had left. The answers we were given were vague and they told us a date for withdrawal had not been identified and that plans were yet to be agreed.

At our inspection in September 2016 we found the provider did not always have people's best interests at the heart of their service. They had been resistant when offered support, guidance and advice from community, health and social care professionals. There was a lack of insight and vision as to how they intended to improve the service. Systems for monitoring the quality of care were not robust enough and had failed to identify the serious failings of the service. The provider and staff lacked understanding and passion in, providing high quality person centred care.

A number of the provider's policies and procedures needed reviewing, many were dated 2013 and contained out of date information. This meant staff were not able to benefit from up to date written advice and guidance.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Systems had not been put in place to ensure people were safe from the risk of financial abuse. At our last inspection we noted, the provider/ manager had failed to follow best practice by ensuring arrangements to manage people's finances were transparent and had not arranged for any independent audit of these records. We recommended the provider reviewed the systems for supporting people to access and manage their finances. Since then a full financial audit had been completed by the local authority. This had resulted in a number of actions for the provider. This included a full reconciliation of monies charged to people for holidays and activities against the actual costs incurred. One person shared their concerns regarding this with us. They said they felt they had been over charged for activities, including holidays. They said they had

received some re-imbursement but felt they may be owed more money. This work is ongoing.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The provider and senior staff had not always submitted notification forms to CQC as required by law. These notifications informed CQC of events happening in the service. Since our inspection in September 2016 there had been one occasion where a notification had not been submitted. This was in relation to one person who required hospital treatment following an error with the administration of their medicines.

This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

When we inspected in September 2016 we found the experience of people using the service was of a closed environment. They lived at the service, used the day care facilities at another location managed by the provider and, activities and holidays took place mainly in groups. This raised the risk of people becoming further isolated from their family and friends and the wider community. This had not been recognised as a risk factor. The overall impression of the service at that time was that it was deskilling people rather than promoting their independence, value and self-worth. At this inspection we saw some improvements had been made following the input from the 'turnaround team'. People were now able to experience greater community involvement and more input from other health and social care professionals. Staff we spoke with recognised the benefits of this but were not confident this would continue when the when the 'turnaround team' were no longer in charge and the provider takes back control.

At our inspection in September 2016 we found staff were not always clear regarding their roles and the lines of accountability. When faced with any emergency situation staff were not clear what to do, in order to respond promptly. This particularly applied to two occasions where staff should have contacted emergency services for medical assistance but rang the provider before doing so. There was no formal on call system in place for staff. They told us the provider lived close and could be contacted at any time. They were not clear what they would do if they were not available.

During this inspection we saw an 'on call' system had been put in place by the 'turnaround team'. This meant staff had access to a senior person when they needed them. We also saw further guidance had been developed which gave staff clear guidance on how to respond to emergencies.

At our last inspection in September 2016 we found the provider was not displaying the most recent review of their performance on their website. We found at this inspection the provider had ensured their website included a link to our most recent inspection of the service.

On 16 February 2017 we gave feedback on our findings up to that point. The feedback session was attended by the project manager, two members of the 'turnaround team', the acting manager and the assistant managers from each of the provider's three locations. Our overall feedback noted the positive improvements in the service provided, whilst highlighting our concerns regarding the sustainability of these. We also discussed new areas that were of concern we had identified during our inspection.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always submitted notifications as required by law. (18) (2).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider had not ensured there was a registered manager in post to manage the regulated activity.

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not worked effectively with other health and social care professionals to effectively assess service users' needs. (9) (3) (a). The provider had not ensured service users' care and support was designed to meet their needs, wishes and aspirations. (9) (3) (b).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care and support was provided in accordance with the Mental Capacity Act 2005. (11) (1).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not actively worked with others to make sure the care and support service users received was safe. (12) (2) (c). The provider had not put in place measures to prevent and control infection. (12) (2) (h).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

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 The provider had not protected service users from the risks of financial abuse. (13 (3).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and improved the quality and safety of the service because they did not have arrangements in place to ensure improvements would be sustained. (17) (2) (a). The provider had not ensured policies and procedures were kept up to date. (17) (2) (d).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had received the training required to meet the care and support needs of service users. (18) (2) (a).

The enforcement action we took:

Notice of Proposal to cancel provider's registration has been issued.