Independence-Development Ltd

Edwin Therapeutic Unit

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Edwin Therapeutic unit is a residential care home providing personal for up to three people who have complex needs. This includes people with a learning disability, autistic spectrum disorder, mental health difficulties an eating disorder and behaviours which challenge the person and/or other people. There were three young people aged under 18 living at the service at the time of the inspection, although one young person was temporarily living in respite care.

Accommodation was provided over three floors. There were two communal lounges and a small garden and utility room to the back of the care home.

People's experience of using this service and what we found
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support best practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care did not always maximise people's choice, control and independence. The behavioural reward system did not always follow the principles of Positive Behaviour Support (PBS). The aim of PBS reward systems is to encourage positive behaviours. However, one young person's reward system did not focus on their positive behaviours, which constituted a punitive approach. This was because some behaviours were out of their control due to their complex mental health.
Right care:
• Care was not always person-centred as it did not promote people's dignity, privacy and human rights. Personal information about young people and staff had been shared with other young people and staff. Young people had been blamed by a staff member for an event which had taken place at the service. As a result, the young people were anxious, one of them believing inaccurately that as a result they were going to be arrested by the police.
Right culture:
• The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives. There was a high turnover of staff who had not received consistent support. This impacted young people as they did not receive consistent support from

staff they knew well. It also limited their ability to form long-lasting and positive relationships with staff as staff members and their assigned keyworker kept changing.

The service was not well-led as the registered manager and provider did not have full oversight of the service. Quality monitoring systems continued to be ineffective and lacked the robustness to identify shortfalls and drive continuous improvement in the service. Feedback from social care professionals was that the service was 'reactive' rather than 'proactive'.

Young people were not always treated well and with dignity and respect which had a negative impact on their well-being.

Young people were not consistently supported and encouraged to maintain a balanced diet. Young people had put on weight and their food records contained a lot of unhealthy fast foods. We made a recommendation the provider seeks national guidance that promotes healthy eating for young people.

The management of medicines had deteriorated which put young people at risk of serious harm. High risk medicines were not stored safely and there were discrepancies in medicines records so it could not be assured young people had taken their medicines as prescribed by their doctor. We sought immediate assurances from the provider on obtaining a suitable medicines cabinet and the steps they planned to take to address the unsafe medicines practices detailed above. We will check how the provider has implemented this action plan at our next inspection.

We made a referral to the fire service due to concerns about fire doors which did not close in the event of a fire and limited access to fire extinguishers.

When things went wrong lessons were not learned nor action taken to help improve young people's safety. There continued to be incidents about young people locking or unlocking doors and causing them or others harm.

Assessment of risk did not always include clear guidance for staff on how to keep young people safe. Staff were advised to use 'reasonable force' when people exhibited behaviours, but there was no definition of what this constituted. There were no formal meetings to discussed what strategies worked well with young people. Staff passed information to one another in the communication book, but this information was not used to update peoples' care plans.

We were not assured the provider was making sure infection outbreaks could be effectively prevented or managed. The registered manager did not take an active role or have oversight of infection control prevention. The provider's infection prevention and control policy was not up to date. At the inspection, we had to remind staff to ensure their face masks covered their noses.

It was not evident the service always followed safeguarding policies and procedures. When reviewing a safeguarding incident, the registered manager stated staff should have contacted the police but hadn't taken on this responsibility themselves. The registered manager was not able to explain the reasoning behind their decisions and the provider, who was the designated safeguarding lead, was not able to add anything further to this safeguarding incident.

Staff training plans were not designed around young people's care and support needs. Not all staff had undertaken training in positive behavioural support, which underpinned the service; or mental capacity. Bank staff had undertaken limited training. Staff supervision and support was not consistent and did not

meet staff's expectations or needs. Staff did not receive monthly or regular supervision with their line manager; nor did assistant psychologists attend six weekly clinical supervisions, as set out in their job descriptions.

Staff were checked that they were suitable to work with young people before they started to support people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 29 April 2021). The provider was in breach of regulation as there was not effective oversight to monitor and improve the quality and safety of the service. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the provider was still in breach of this regulation. In addition, we found a further six breaches of regulation with regards to treating people with dignity, providing person-centred care, protecting people from abuse, medicines management, staff training and supervision and infection control.

Why we inspected
The inspection was prompted in part due to concerns received about keeping young people safe, assessing their needs, acting on concerns and the overall management of the service. A decision was made for us to inspect and examine those risks and undertake a comprehensive inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management and oversight of the service, medicines, infection control, complaints, keeping people safe, staff training and supervision, meeting young people's needs, protecting young people from abuse and treating them with dignity and respect at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Edwin Therapeutic Unit

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type:
Edwin Therapeutic Unit is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection here
We sought and received feedback from commissioners of the service, the local authority safeguarding team and the social workers of the three young people living at the service. We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support

our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four staff members including the registered manager, two support workers and the provider who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two young people's risks assessments and medicines records. We looked at staff training, supervision and staff rotas. A variety of records relating to the management of the service were reviewed including accidents and incidents and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The provider sent us the recruitment records of three staff and information about the matching process of young people as requested in a timely manner. A matching process is used to ensure that young people who move to the service are compatible with those young people who already live there.

We telephoned a relative to gain feedback about young people's experiences of using the service. We spoke with young people's social workers to help us gain an understanding of their views about the service. We also spoke with two additional support staff.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection, this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● At the last inspection, people were at risk of harm due to poor medicines management. After the inspection, the registered manager gave assurances that medicines management had improved as they and a senior staff member were responsible for medicines checks. We found medicines management had deteriorated and young people continued to be put at risk of harm by unsafe medicine practices.

● Medicines were stored unsafely. Medicines, including medicines which are at a higher risk of misuse and therefore need closer monitoring, were not stored securely in line with legislation and national guidance. This made medicines easier to access for young people, some of whom had been assessed as at risk of self-harm.

● The registered manager did not know that some medicines were kept in a cupboard which was not secure as it was not a designated medicines cupboard. The temperature of the cupboard was not checked to ensure medicines were kept at the right temperature, so they were fit for use. This is because some medicines change in composition when exposed to excessive high or moisture.

● At the last inspection, the provider was not clear about their responsibilities and role in relation to medicines. At this inspection, this continued to be a concern. The number of medicines in stock did not reconcile with the number of medicines administered to young people. There was one less medicine in stock of a medicine which is at higher risk of misuse and therefore need closer monitoring. The provider was not aware of this error and therefore had not taken immediate steps to investigate if it was a recording error or if the medicine was missing.

● Checks on medicines were ineffective. The last stock count on 10 October 2021 had identified that there should be 25 tablets to treat one person's anxiety and one person's mental health condition. However, staff had counted 46 tablets of each medicine in stock. No action had been taken to find out if people had not received these medicines as prescribed by their doctor.

● National guidelines were not followed for medicines prescribed as to be taken 'as needed' (PRN) and when young people spent time away from the service. Two young people had been prescribed medicine PRN to help them sleep. There were no protocols to direct staff under what circumstances young people should be given these medicines. Documents to complete when young people went on social leave were not recorded as intended. The section to reconcile how many medicines left the service and returned to the service had not been completed on any of the records. A social care professional told us that when a young person went on social leave the number of medicine tablets they were given did not reconcile with medicines records. There was a risk young people had not been given their medicines as prescribed which could affect their physical or mental health.

● Medicines were not returned to the pharmacy for disposal in a timely manner. There was a loose box of sleeping tablets which should have been returned to the pharmacist nine days earlier. Each time the box

was removed from the medicine's cabinet, some of these very small tablets fell on the floor. There was a risk some of these tablets could get missed and remain on the floor for someone to ingest.

We sought immediate assurances from the provider on obtaining a suitable medicines cabinet and the steps they planned to take to address the unsafe medicines practices detailed above. We will check how the provider has implemented this action plan at our next inspection.

The provider had failed to operate a safe system for the storage, administration, recording and disposal of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● When things went wrong lessons were not learned nor action taken to help improve young people's safety.

● In December 2020 a young person locked themselves in a room and harmed staff. In the same month we were notified that a young person had unlocked a door and gained access to a dangerous object. Lessons had not been learned in providing suitable locks at the premises. In October 2021 a young person locked themselves in a room and caused themselves harm as staff were not able to unlock the door in a timely manner.

● Reviews of significant events were insufficient. At the last inspection we found there was no overview of incidents relating to young people's anxieties and associated behaviour. At this inspection the registered manager told us they had a plan to instigate a learning curve from events. They were not aware that this omission had already been identified at the last inspection as a breach of regulation.

● The provider told us they had recruited trainee assistant psychologists to analyse incidents and identify any patterns or triggers for young people's behaviour. However, this had not occurred due to the high turnover of staff. The provider had completed a detailed graph of one young person's behaviours since February 2021. They had yet to update this persons' care plan so this information could be used to guide staff in the best ways to support the person.

● Social workers told us weekly reports of young people's well-being and outcome of incidents were inconsistently received. They also said they did not always give a clear overview of young people's care.

Assessing risk, safety monitoring and management

● There was inconsistent practice in the assessment of risk and safety monitoring. Young people had complex needs and potential risks in their everyday lives had been identified. Guidance for staff included preventative measures; and also, reactive strategies if preventative measures were unsuccessful. However, information and guidance for staff in how to support young people in high risk situations was not always clear or coordinated.

● Reactive strategies in young people's risk assessment guided staff that, 'reasonable force may be used if necessary'. There was no guidance to staff about what constituted 'reasonable force' for each individual and in different circumstances.

● Information about risks to young people was not passed to staff in an effective manner. Staff were required to read and sign each person's risk assessments, to acknowledge their understanding, but this had not always occurred. Staff completed records of what happened before, during and after incidents with young people. Staff told us if a particular strategy worked well or did not work well, they would record this in the persons' daily notes and staff communication book. This information was not used to update young people's support plans and associated risk assessments. There were no group staff meetings to discuss what worked well with young people so young people and staff could be kept as safe as possible.

● Risk assessments contained information about how to minimise risk to people who may harm themselves,

such as one to one staffing and ensuring dangerous objects were kept locked. However, young people's risk assessments had not been updated when young people had got access to dangerous objects.
● The provider only took action to ensure young people would be safe in the event of a fire, after we brought our concerns to their attention. At the inspection three fires doors did not close properly. The provider told us the fire doors would be repaired within two days of this being brought to their attention. We made a referral to Kent Fire Service due to the risks to staff and young people's safety. The Fire Service visited the service after the inspection and found the provider had taken the necessary steps to keep people safe.

The provider had failed to assess, analyse and mitigate risks to young people's safety and welfare so improvements could be made to care delivery. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Young people had not always been protected from physical and emotional abuse.
● As detailed above, one young person harmed themselves as staff were not able to unlock the door to the room they were in, in a timely manner. As detailed in the caring domain, some young people suffered emotional abuse as a staff member told them they were responsible for a significant event at the service.
● There was mixed feedback from social care professionals about the effectiveness of the service to keep young people safe from harm. One young person had clearly fed back to their social worker that they felt happy and safe at the service. However, another young person had temporarily left the service due to concerns about their safety.
● Although the registered manager knew how to recognise abuse, it was not evident they understood how to follow safeguarding policies and procedures. When reviewing a safeguarding incident, the registered manager stated staff should have contacted the police. When asked if they did contact the police the registered manager responded that they had not. They were not able to explain the reasoning behind their decisions. The provider was the designated safeguarding lead but was not able to add anything further to the safeguarding incident.

The provider had failed to ensure there were effective systems to protect people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff knew how to recognise and report potential abuse. They had undertaken training in safeguarding children and adults. Staff understood their responsibility to raise any concerns to the registered manager or provider. They also knew how to contact the local authority safeguarding team.

Preventing and controlling infection
● At the last inspection we sought and received immediate assurances from the provider on their processes for effective control and prevention of infection. At this inspection, We not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The registered manager did not take an active role or have oversight of infection control prevention. They did not know who to contact to seek advice from in the event of a COVID-19 outbreak.
● We were not assured that the provider's infection prevention and control policy was up to date. The policy was dated 21 December 2020 and did not include new national guidance including details of staff vaccinations, testing and visiting procedures.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There continued to be gaps in the cleaning record which indicated staff were not following the twice daily cleaning schedule of frequently used areas of the service. We found the sofa in the

upstairs lounge was sticky to the touch before staff cleaned it during the inspection visit. This indicated the sofa where young people and staff sat together had not been cleaned regularly.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Although the registered manager said all visitors' temperatures were taken and COVID-19 tests checked, on arrival, we had to prompt the registered manager to do this.
● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. This was because although staff were wearing face masks, they did not always cover their mouths and nose to be effective.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

The provider had failed to ensure there were adequate systems to prevent and control the spread of any infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Young people were supported by the number of staff as assessed by the placing authority. However, turnover of staff was very high which put young people with complex needs at risk of receiving inconsistent and unsafe care. Long-term staff knew people well, however, out of the ten staff employed at the service, only one had worked at the service for over a year. Two staff had started the week of the inspection, four staff within the last six months and three staff had been employed between three and six months.
● The registered manager told us they had let a lot of staff go as they were not suitable for the role. They told us, "When we asked them to buck their ideas up or leave, they left and then reported us to CQC."
The provider told us the high turnover of staff was partly due to 12-hour shifts which was part of their employment contract, and expectations that they would be more involved in the psychology. High staff vacancies and staff sickness had resulted in staff working extra 12 hour shifts to cover gaps in the rota. This in turn had led to low staff morale. Staff told us morale was improving gradually as new staff were recruited.
● Young peoples' staffing support needs were jointly assessed and reviewed with young people's social workers. Staffing rotas evidenced that young people's one to one and two to one staffing needs were provided by the staff team. Shortfalls in staffing were provided by one bank staff and agreements were in place for staff who had opted out of working up to 48 hours per week.
● Appropriate checks were carried out on potential staff which included obtaining a person's work references, full employment history, right to work in the UK and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with young people who use care and support services.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff training plans were not designed around young people's care and support needs. Positive behavioural support (PBS) did not always underpin young people's care and support at the service. PBS is used to support people who present behaviours that may challenge in the most appropriate way.
- The deputy manager and three staff, including both bank members of staff, had not undertaken training in PBS. This impacted on young people as there is evidence in the caring section of this report of punitive reward systems being used and not treating people with dignity and respect.
- Furthermore, neither bank staff had undertaken training in health and safety, fire, first aid, food hygiene or mental capacity. The deputy manager and another support worker had not undertaken training in mental capacity.
- At the last inspection the provider told us about their plans to roll out mental health first aid training to the staff team. This was particularly important as some young people displayed self-harming behaviours. The provider told us accessing face to face training had been difficult due to the pandemic. At this inspection first aid training continued to be provided on-line, rather than through practical experience and only one staff member had completed mental health first aid training. There was a risk of putting young people at further risk of harm as staff did not have the practical experience or skills to provide emergency first aid to young people when they self-harmed.
- Staff supervision and support was not consistent and did not meet staff's expectations or needs. Staff told us they did not received supervision at the frequencies set out in their job descriptions. The purpose of supervision is to provide staff with support, assurances and learning, to help their development. Clinical supervision also focuses on exchanges between practicing professionals which may promote debate, challenge existing thinking and generate solutions to supporting the young people in their care.
- Staff did not receive monthly or regular supervision with their line manager; nor did assistant psychologist attend six weekly clinical supervisions, as set out in their job descriptions. An audit of staff supervisions recorded that only two staff had received supervision in the last six months. The provider said it had not been possible to hold staff clinical supervisions every six weeks and had not planned any future dates going forward. Staff confirmed they did not receive clinical supervisions to the required frequency.

The provider had failed to ensure there were suitably qualified and competent staff to support young people; and that staff received the professional development and supervision necessary to enable them to carry out their roles.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Staff induction included shadowing staff and an assessment against the standards of the Care Certificate. To achieve this award staff must prove that they have the ability and competence to carry out their job to the required standard.

Supporting people to eat and drink enough to maintain a balanced diet
● Young people had a complex relationship with food which made it challenging for staff to support them to maintain a balanced diet.
● Although young people were involved in planning healthy meals and there was information about healthy eating in the kitchen, food records showed young people eat unhealthy snacks. Everyone had gained weight since moving to the service. One person had put on 18 kg within a six month period. This person's food record contained a lot of unhealthy and fast foods, treats and snacks. We found no evidence that young people had been referred to their doctor or dietician to gain professional support.
● Staff explained that young people were able to make their own choices and decisions with regards to food. It was not evident that national guidance was being followed in which young people are given informed choices, praise, encouragement and role modelling in order to enable them to eat healthier.

We recommend the provider seeks national guidance that promotes healthy eating for young people.

Supporting people to live healthier lives, access healthcare services and support; Staff providing consistent, effective, timely care within and across organisations
● Young people were not always supported to live healthier lives. This was because their diets were not consistently healthy. Nor was there evidence of people assessed as requiring exercise undertaking this regularly.
● Young people had complex health needs which had been identified and were monitored by staff.
● Young people were supported to access health care and mental health care appointments. Records were made of these visits, so this information was available to the staff team.

Adapting service, design, decoration to meet people's needs
● Feedback from social care professionals and relatives about the overall environment was mainly negative, with one person describing it as, "Sad" and "Tired." The dining room was in the basement with no natural light. The corridors were narrow making it difficult for young people to pass one another, which was not ideal for young people with complex and challenging needs.
● Risks in relation to premises and equipment had not always been identified, assessed and well managed. We made a referral to the Fire and Rescue Service due to concerns about young people's safety in the event of a fire.
● Young people were able to personalise their rooms with things that were important to them. They had access to a large lounge on the top floor of the service.

We recommend the provider seeks guidance from a reputable source about the design and decoration of the environment and consult with young people who live at the service.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● We could not be assured MCA principles were consistently put into practice as four staff had not received training in MCA.

● When young people had been assessed as not having the capacity to make specific decisions, discussions were held with relevant professionals and family members, to make a decision in the person's best interest.

● Some young people had specific conditions about restrictions on their liberty as set out in a DoLS. These restrictions were incorporated into the person's care plan, so the staff team were aware of these lawful restriction on the person's freedom.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● A social care professional had raised concerns with the provider after reviewing the matching tool for a potential young person moving to the service. A 'matching tool' was used to assess the risks and compatibility of each young people living together at the service. The match had not been successful and one of the young people had moved out of the service. The registered manager told us they had no input in the matching process.

● Before people moved to the service, the provider obtained information about people's assessed needs from the local authority. This included information about people's education, family and social relationships, healthcare and personal care needs.

Inadequate

Is the service caring?

Our findings

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

At the last comprehensive inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring people are well treated and supported; equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Young people were not always treated well and with dignity and respect.
- Social care professionals told us a member of the staff team had been very unkind to the young people. They had said young people were to blame for an alleged event at the service. This was unprofessional, untrue and had had a serious and widespread negative impact on the young people. One young person believed as a result that the police were going to arrest them. The provider told us they had investigated but had not been able to identify the staff member concerned. Staff described how they were doing their best to support the young people through this unsettling emotional time.
- At the team meeting on 5 August 2021 the registered manager advised, 'When you are now discussing a service user the door to the office is to be shut. If it comes to it, I will make sure it is rule it is shut all the time." This was because personal information about young people and staff had been shared with other young people. However, at the inspection the office door was open, and a young person came into the office. The registered manager did not take any action and we asked for the office door to be shut so our conversation about young people's care and treatment remained private.

The provider had failed to ensure young people were treated with dignity and respect at all times. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Young people could not be assured that staff knew them well including their personal histories and preferences. Although staff completed a short induction which included reading young people's care plans and history, there was a consistent high turnover of staff. Half of the staff team had worked at the service for less than six months. One young person had, on average, nearly a new keyworker each month. This did not fit in with the aim of the service to develop, 'Therapeutic relationships, working with the service user to form strong and stable attachments between adults (practitioners) and the service user as a prerequisite for the development of trust and meaningful changes and developments needs for improving the service user's life chances'.
- Feedback from social care professionals and relatives was that longer-term staff members had developed positive and caring relationships with young people.
- Young people's needs in respect of their disability, gender, culture, beliefs and sexual orientation were identified in the care planning process.

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

● Young people attended keyworker meetings where they were involved in making choices and decisions about their care and support. One of the aims of the service was , 'To provide an effective keywork system as it is evident that this relationship can work well for service users and sometimes is the way forward with developing the first attachment with an adult that will not be abusive to them'. However, these meetings had been inconsistent due to the high turnover of staff which impacted on young people developing such relationships with staff. This is an area for improvement.

● To help promote young people's independence they were given a budget for food and activities. They were involved in varying degrees in cleaning, meal planning, cooking and doing their laundry.

● Young people had been involved in agreements about the house rules, so they understood their responsibilities.

Requires Improvement

Is the service responsive?

Our findings

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

At the last comprehensive inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- Some guidelines in young people's care plans were punitive and did not give young people choice and control.
- A behavioural reward system was used as part of the Positive Behaviour Support (PBS) approach, to encourage positive behaviour in young people. Young people were in control of assessing how much monetary reward they should receive, based on their behaviours for the week. However, one young person's reward system stated that £1 should be deducted for certain behaviours. The registered manager said the decision on how much reward young people received was her responsibility and they had been taking away £2 for negative behaviours. The provider said that this was 'punitive' and should not be happening. Punishing young people for negative behaviour does not follow PBS principles. Young people do not always have control over their behaviours due to their complex mental health conditions.
- Young people's care plans contained personalised information on their physical, mental, emotional and social needs. There was guidance for staff on how to support people in the most effective way. However, this guidance had not always been updated when there were changes in people's needs. Young person had complex relationships with food. These had not always been recorded in their plans of care, together with the support they required to maintain a healthy diet.
- One of the values of the service was that, 'We believe that people themselves are best placed top determine what they need and what goals they wish to achieve.' The aim was for progress towards goals to be discussed with young people at keyworker meeting. However, these meetings had not taken place regularly. One young person had had only three such meetings in the previous six months.

The provider had failed to ensure the care and treatment of young people was appropriate and met their assessed needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The complaints system was ineffective. When young people had raised complaints or concerns these had not investigated or used to improve or change the service.
- The provider's complaints audits recorded there had been one complaint in March 2021 which had been resolved and none in April 2021. However, there had been two complaints in March and two in April.
- There was no information about how first the complaint in March 2021 had been resolved. The section on the complaint form to add how and if the complaint had been resolved to the young person's satisfaction was blank. It was recorded that the second complaint in March had been passed to the provider and registered manager. There was no information about any investigation or further contact with the

complainant to resolve the issue.
● In April 2021 it had been recorded that a young person had 'asked for a complaints form and completed it in the office with help' and on another occasion that they had, 'filled out a complaint form'. The provider and registered manager did not know where these complaint forms were located. There was the risk that this young person may not feel confident to raise any further concerns, as when they had done so they had not been acted on.

The provider had failed to establish and operate an effective system for receiving, recording, handling and responding to complaints. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There was mixed feedback on whether young people were able to fully follow their interests.
● Whistle-blowers told us some young people were left in their bedrooms for long periods of time with limited staff interaction. This was despite staffing levels being one to one or two to one.
● Young people were supported to go shopping, swimming and to the cinema as keeping young people interested and occupied helped to reduce some behaviours. There were mixed responses about whether this was being achieved.
● Some young people were in education or employment arranged by other agencies. They were supported to maintain and develop relationships with people who were important to them such as family and friends. Young people kept in contact with their loved ones by telephone and visits. Some young people had developed friendships with young people at another of the provider's services.
● Some young people kept a pet. When this occurred, the young people was responsible for their pet's care and upkeep.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Key documents such as the forms used to make a complaint and the house rules were written using words and pictures to help young people understand their content.
● Some young people used alternative communication methods, such as picture exchange communication systems (PECS). Key Information was available in PECS, so young people could understand its content.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to have effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service was not well-led as the registered manager and provider did not have full oversight of the service. Quality monitoring systems continued to be ineffective and lacked the robustness to identify shortfalls and drive continuous improvement in the service.
● Shortfalls identified at the last inspection in quality monitoring, medicines and infection control had not been fully addressed. The management of medicines had deteriorated further putting young people at serious risk of harm. There was a lack of oversight in infection control practices. In addition, the provider had failed to identify shortfalls found at this inspection in staff training and supervision, acting on complaints, providing young people with appropriate care and consistently treating young people with dignity. This impacted on young people's care as they could not be assured staff had the skills and knowledge to support them safely; and that if they raised a concern or complaint it would be taken seriously. There was a high turnover of staff which meant that young people were not given the best opportunity to establish trusting relationships with staff. Young people had not been treated with dignity due to being subjected to punitive measures. They had also been deeply affected in a negative way as the result of a staff member saying they were to blame for something which had taken place at the service.
● Feedback from social care professionals and relatives was that the service was 'reactive' rather than 'proactive'. One of the aims of the service was that, 'Informal group work is undertaken during normal routine running of the units and practitioners are aware of issues of group development and group dynamics. Where problems need to be solved by the group or the issues to be addressed such as integration, the practitioners may employ development group work techniques.' This group work did not take place and there was little evidence of learning, reflective practice or service improvement.
● There had been a lack of communication between the registered and deputy manager. When asked about an aspect of medicines management the registered manager responded, "I don't know anything about it. That was the deputy manager". The provider told us at the time of the inspection that the deputy manager

was no longer carrying out this role.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider and registered manager did not have oversight of the culture of the service to ensure it met its visions and values.

● The visions and values of the service were not always met. The keyworker system which aimed to develop trusted relationships between young people and staff was ineffective due to the high turnover of staff. Dignity and respect was not promoted in the way some staff used the behavioural reward system. Assistant psychologists had not had opportunities to work together to help explore the reasons for people's behaviours.

● Management communications to staff were not always delivered in a way which demonstrated staff were valued. One staff member described them as 'passive aggressive', Passive-aggressive behaviours are those that involve acting indirectly aggressive rather than directly aggressive.

● Whistle blowers told us there was a poor culture within the service and a lack of support. They said there was a blame culture at the service which was not based on respect and inclusion for everyone.

● Young people had monthly goals and targets. However, as keyworker sessions were inconsistent, it was not evident if these goals were developed with the young person, so they were person-centred, or directed by staff.

The provider had failed to have effective systems to assess, monitor and improve the quality , safety and culture of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider had not always acted according to the principles of the duty of candour. The duty of candour principles are that providers are open, honest and transparent with people and others in relation to care and support.

● The registered manager was unable to demonstrate an understanding of their obligations under duty of candour.

● The provider notified us about an incident which put young people and staff at risk of harm. A young person had unlocked a door to gain access to a harmful object. As a result, one of the providers actions to minimise the risk of the same happening again was to change the lock on this door. However, a social care professional told us the provider had since learned that the young person had gained access to the harmful object due to staff error. The registered manager was unable to demonstrate an understanding of their obligations under duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Keyworker meetings whose focus was engaging and involving young people, were inconsistent . This was due to the high turnover of staff which made it difficult for young people to form trusting attachments with staff. Some young people were reluctant to participate, and long-term staff had used pictures to help young people describe how they were feeling.

● When young people had made complaints about the service, these had not always been investigated or acted on to improve the service.

● Opportunities for staff support were limited due to the infrequency of staff meetings, supervisions and clinical meetings. There was mixed feedback from staff on how this impacted staff well-being. Some staff

said the registered manager was kind and approachable. Other staff said they received no support and that staff were left to manage the service by themselves.
● There was regular communication between young people and their relatives.

Working in partnership with others
● Feedback from social care professionals was that there were sometimes delays in receiving information requested from the provider. Weekly reports about young people's care were also not consistently received.
● Staff and the management team)had established relationships with health care professionals such as GP's and mental health workers to help provide joined-up care.
● Regular communication had been established by staff with teachers when young people attended school or college.