Independence-Development Ltd

Edwin Therapeutic Unit

Inspection report

82 Edwin Street
Gravesend
Kent
DA12 1EJ

Tel: 01474323891

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Edwin Therapeutic Unit on 8 March 2017. This inspection was done in response to information of concern we received from the local authority. Edwin Therapeutic Unit is a care home registered to provide accommodation and personal care for a maximum of three people who have learning disabilities, autism spectrum disorder, mental health issues and behaviours that challenge. It specialises in supporting people to manage high levels of behaviours that challenge. People required a range of support in relation to their support needs. At the time of the inspection there was one person living in the service, although we reviewed some documents relating to other people who had moved from the service prior to our site visit.

The service was based in central Gravesend close to the town centre and its shops and amenities. The service was in a quiet residential street and consisted of three bedrooms over two floors, an office, a communal lounge, a kitchen and two bathrooms. There was a small garden accessed by people in the rear of the property.

The service did not have a registered manager. 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. We spoke to the registered provider about this and were told that another manager would be taking over management of the service with another service as a dual registration.

The provider did not have effective systems in place to protect people against abuse and harm. The provider had up to date policies and procedures but did not give staff correct guidance on how to report abuse in line with the Health and Social Care Act 2014 or the local authority's safeguarding adults policy, protocol or guidelines.

Risks were not consistently assessed and managed to keep people safe from avoidable harm. Some risks assessments were out of date and staff did not have access to one person's risk plan for managing their behaviours that challenge.

Assessed staffing levels had not consistently been adhered to. Some incident reports showed that where three staff should have been on shift there were on occasions only two or one staff member supporting three people who were funded to receive one to one support.

The principles of the Mental Capacity Act 2005 were not consistently being adhered to. Where people were assessed as not having the capacity to make a certain decision a best interest meeting was being held; however, only one person was recorded as being involved in the decision.

Food safety checks had been carried out regularly. There was a menu for people to choose food from and

have input to. People had enough to eat and drink, and received support from staff where a need had been identified. However, there was a lack of fresh fruit and vegetables being recorded as being eaten by people and Staff did not consistently support people to eat healthily.

Care plans were not personalised and did not contain enough information on how to motivate people to engage with their support programme. One person had recommendations made by a psychologist but these had not been included in the person's care documents.

Complaints were not consistently used as a measure to improve the service delivered to people. Not all complaints were being recorded which meant that the service could not learn, and make improvements, from people's experience.

The registered provider did not always keep up to date with current legislation and national guidance. Advice given to care workers around safeguarding vulnerable people was not in line with the local safeguarding policy or legislation. The registered provider did not have appropriate knowledge of the Health and Social Care Act 2008 and CQC Registration Regulations 2009.

The registered provider did not have effective systems in place to monitor the quality of care and support that people received. Quality audits had not been completed since April 2016 and there was no other documented evidence of managerial or senior management oversight of the service in the absence of a registered manager.

The registered provider was not aware of their responsibility to comply with the CQC registration requirements. They had not notified us of all events that had occurred within the home and had moved a person from the service to an unregistered location without applying for urgent registration.

Medicines were being stored and administered safely by staff who had received training on medicines administration. Audits were happening and the stock check of medicines was correct, but the system for auditing did not have an expected stock check meaning that errors in the future could be missed. We have made a recommendation about this in our report.

The staff were kind and caring. Good interactions were seen throughout the day of our inspection, such as staff sitting and sharing conversations with people as equals. People spoke positively about the care and support they received from staff members.

People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

Staff were trained with the right skills and knowledge to provide people with the care and assistance they needed. Staff were able to meet their line manager on a one to one basis regularly. When staff were recruited they were subject to checks to ensure they were safe to work in the care sector.

The culture in the service was homely and there was an informal and friendly atmosphere where people felt able to take the lead in their lives.

People had access to healthcare professionals to meet their needs and we saw records that people had been registered with local primary healthcare services and had been referred to specialist services when required.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If sufficient improvement is not made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

The registered provider had not ensured that people were safeguarded from abuse. Staff had been given advice on reporting safeguarding incidents that was not in line with local policies and legislation and had led to under reporting of incidents.

Assessed staffing levels had not always been provided. Some incidents showed that staffing levels were lower than levels that had been assessed as being safe for people.

Risks were not consistently and safely managed. Some risk assessments were out of date and one person's care plan for behaviours that challenge was not available to staff.

Medicines were being managed, stored and administered safely and people received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had sufficient food and drink to meet their needs. However, there was a lack of fresh fruit and vegetables being recorded as eaten by people.

Staff had access to training to ensure that they were skilled to meet people's needs.

The principles of the Mental Capacity Act 2005 were not consistently adhered to. Best interest meetings only recorded one person's decision and not all capacity assessments were clear in their judgement.

People had access to a wide range of health and social care professionals and had their healthcare needs met.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information about people to support them and build up caring relationships.

People were involved in their lives and could make decisions about their care.

People were treated with dignity and respect and their independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not personalised and did not contain enough information on how to motivate people to engage with their support programme.

There was a complaints policy and system for recording and responding to complaints. However, we found that complaints were not being recorded.

Is the service well-led?

Inadequate

The service was not consistently well led.

Effective systems were not in place to monitor the quality of care and support that people received. Quality audits had not been completed since April 2016.

The registered provider did not always keep up to date with current legislation and national guidance. The registered provider was not aware of their responsibility to comply with the CQC registration requirements. and did not have appropriate knowledge of their legal responsibilities under the Health and Social Care Act 2014.

The culture in the service was friendly and homely and people felt able to take the lead in their daily life.

Edwin Therapeutic Unit

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.

The inspection took place on the 8 March 2017 and was unannounced. The inspection was carried out in response to concerns raised to us by the local authority safeguarding adults and commissioning team who had visited the service and found a number of areas of potentially poor practice following changes in the service. The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service. We considered information we held about the service: this included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to submit a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority safeguarding adults team and the local authority commissioning team to obtain their views on the care provided in the service.

During the inspection we spoke with one person. We spoke with various staff that included the deputy manager, one permanent care staff and the registered provider. We observed the care and support being provided and talked with other people involved with people's care provision during and following the inspection.

We looked at one care plan and associated risk assessments, four staff files, medicines administration record (MAR) sheets, incidents and accidents logs, policies and procedures and other records relating to the management of the service. We also 'pathway tracked' one person living at the service. This is when we followed the care and support a person received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We last inspected Edwin Therapeutic Unit on 14 and 15 June 2016 where it was rated 'Good'.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Edwin Therapeutic Unit. One person told us, "I feel safe here. The staff keep you safe and look after you better than the last place." Staff we spoke with displayed an understanding of the registered provider's safeguarding policy. One staff member told us, "If there's an incident I would fill in an incident form and if I feel unsure there's a helpline I can call. I did this when X hurt his eye and called the case manager and it was resolved without a safeguarding." Despite these positive comments we found areas of practice that were unsafe.

People were not protected against the risks of abuse, despite the registered providers safeguarding policy being in place and known to staff. We found that some serious incidents had not been reported to the local authority safeguarding adults team or the police. The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the care system should protect adults at risk of abuse or neglect. The local authority is the lead agency in investigating cases of suspected abuse and, as such, needs to be notified of safeguarding incidents. We found one incident report that detailed an incident between two people that resulted in a physical assault. The incident report did not identify that the assault was in fact a safeguarding incident and the section of the incident report for the manager to comment and sign for was not completed. The report recorded that the incident was managed by staff increasing observations and separating the two people involved. However, there is a statutory duty to report this incident as a safeguarding incident and this was not carried out. We raised this issue with the registered provider (registered providers are 'registered persons'). The registered provider told us, "Where people hit each other we try and resolve it within the unit. We're aware now that every time something big happens it should be reported. We haven't reported to safeguarding because the issue is over after staff have stopped the assault and they [people involved] are fine with each other." We explained the legal obligation to report matters to both the local authority multi-agency safeguarding adults team and to CQC, and the registered provider agreed to do this.

Subsequent to our site visit, and as part of our inspection, we contacted the local authority safeguarding adults' co-ordinator to report this incident and to ensure that the local authority was aware of the assault. We were informed that they had visited the service and had found this unreported incident as well as several other incidents of assault and safeguarding concerns that had not been reported by the provider. One of the incidents recorded an assault where the people involved were requesting that the police were called. Staff did not call the police following incorrect advice from the acting manager that the assault could not be reported as the people involved were under a Deprivation of Liberty Safeguard (DoLS). This meant that the registered provider had not ensured that all safeguarding incidents had been reported correctly. Another incident report recorded a serious incident that was not reported and was not responded to appropriately by staff. We checked the safeguarding file and found that there were some instances where incidents had been appropriately reported to the local authority. The safeguarding policy had been revised in April 2016 and contained up to date information, such as new categories of abuse.

The failure to make appropriate referrals to the local authorities safeguarding adults team is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks, however some of these were out of date. We checked generic house risk assessments for potential hazard areas such as the administration of medicines, the kitchen, service users in the community, and fire. All of the generic house risk assessments were out of date. We checked the legionella assessment and found that the legionella risk assessment was out of date and the hot and cold water checks had not occurred since the January monthly risk assessment. In addition the monthly descaling checks for shower heads had not been carried out. We raised this with the registered provider and were told that an external water safety company had been booked to come and test the system. The fire risk assessment was out of date and still showing three people as living at the service. However, weekly fire safety checks were in place, for example, testing of smoke detectors and fire escape routes. There was no record of fire drills or evacuations being completed. The registered provider told us that these had been mistakenly archived.

Environmental risks were being managed effectively through regular monitoring and checks conducted by the acting manager. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. The acting manager ensured that general risks such as slips and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Each risk assessment identified the risk and what actions were required of staff to reduce the risk.

Risk assessments for people were not always available to staff. We requested a copy of one person's positive behaviour support plan [PBSP]. PBSP's are used to teach a person more effective and more acceptable behaviours than the challenging one in order to reduce the challenging behaviour. When we requested a copy the deputy manager was unable to find a copy until later in the afternoon. The plan for managing behaviours that challenge were not readily available to and known by staff which meant that people were at risk. This meant that high level risks to one person were not being managed effectively by staff due to the PBSP not being available to, or known by the staff team. Risks around people's behaviour management were not being managed on a day to day basis because staff did not have access to the information, such as in PBSP's. Prior to our inspection visit we received a report from the local authority highlighting concerns that risks were not being managed effectively. Subsequent to our inspection visit we received a report from the local authority safeguarding adults team outlining concerns around the management of risks.

The failure to safely manage risks is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing numbers in the service were appropriate on the day of our inspection. There was only one person living at the service and they were funded for one to one support hours. The rota showed that there was always one staff member on shift to support the person and that on occasions there was a care worker plus a member of the management team working at the service. However, previous incident reports indicated that staffing levels had not recently been adhered to. One incident report shared with us subsequent to our site visit by the local authority safeguarding adults at risk coordinator from October 2016 stated that one staff member had taken three people into town when each person was funded for one to one support. Another incident report had detailed that two staff member were on shift when the assessed and funded level of support for that day was three staff members.

The failure to provide adequate staff to meet people's assessed needs is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Medicines were being administered, stored and managed safely. There was an up to date medicines policy available for staff members to refer to. An audit of medicines took place once a week in which each person's

medicine was counted. Although there were no errors identified during our inspection, we found that there was no running total for the number of expected tablets. This meant that a staff member may not know the correct number of tablets they should expect for each person when counting tablets. We checked the totals of tablets against the paperwork and found no errors. There was an additional monthly medicines audit which checked areas such as staff training and stock checks, and these were being completed regularly. We saw that the medicines risk assessment identified control measures, such as staff competencies being completed every year and regular medicines reviews with people's GP's. Where people had been prescribed 'as required' (PRN) medicines there was a PRN protocol in place to explain when the medicine could be given and what staff needed to do to maintain the person's safety when taking the medicine. There had been an audit from an external pharmacy in September 2016 which had not identified any serious issues. The management of controlled drugs (CD's) was recorded in a dedicated book that identified how many CDs were in stock and clearly indicated when these were administered or when new medicines were entered in to stock. CDs were kept locked in a separate cabinet as per best practice guidelines.

We recommend the registered provider reviews the way medicines are audited to ensure all future audits are accurate.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The registered provider had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. However, we noted some areas of practice that required improvement. We reviewed MCA assessments that had concluded that the person lacked capacity and which had led to decisions being taken on their behalf. For example, for the decision of a person having a cigarette lighter it was decided that they lacked capacity to understand the consequences of misuse. A best interest decision was made that staff should keep the lighter and staff should accompany the person outside when they smoked. However, on this decision, and all others we saw, there was only one staff member's input recorded. Consultation with appropriate parties had not taken place in the decision making process such as the manager of the service, the key worker, social worker, GP, relatives if practicable or advocate. Subsequent to the inspection, the registered provider informed us that other parties had been involved, that signatures had been added and would in future be evidenced clearly.

In addition we found that some capacity decisions were not always clear. We found several examples where a person's capacity had been found to be lacking in relatively simple matters, such as personal care routine and the use of prescription medicines. However, the decision making process was not apparent and merely recorded that the person lacked capacity. For other matters, such as making healthy choices around food, we were told that the person had capacity to choose unhealthy food options, but there were no mental capacity assessments to show that this had been fully assessed. This meant that the person was making unhealthy decisions about their diet but they may potentially not be able to understand the consequences of these choices. Staff had not explored other ways of explaining information around diet and health choices to the person, such as in picture form or explaining the issues in small instalments. Prior to our inspection the local authority had shared concerns with us about the registered providers understanding of MCA and DoLS.

The failure to follow the principles of the MCA 2005 is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they had the training and skills they needed to meet people's needs. One member of staff told us, "The training I got here was good and it was up to date. Here you're trained, for example, how to restrain people and after any restraint you have to complete a form and describe what you did." One person told us, "I've not been restrained here but I've seen it done. Staff have the training." We checked the training files and

found that a training matrix had been recently implemented. The training matrix for online training was up to date and reflected that all staff had received training in safeguarding. We saw that moving and handling training was being delivered on line and raised this as a potential concern with the registered provider. We were told that as nobody at the service required assistance with moving and handling, and there was no lifting equipment in use, the training was delivered on line. However, we were assured that should a person require support with moving and handling then face to face training would be arranged for all staff.

In addition to on line courses in core areas such as fire safety and food safety there were supplementary courses available to staff, such as, 'Attachments and the stress of forming new attachments through the eyes of autism spectrum disorder'. Competency assessments were in place for certain training courses to ensure that staff had understood them. We reviewed competency assessments for medicines training, mental capacity and deprivation of liberty safeguards training, safeguarding training, and risk assessment training. Staff had to pass the assessment following the training course in order to be able to be signed off as competent. New staff had to complete an induction prior to working on shift at the service. We reviewed the induction checklist for two staff: there was a clear and structured programme for new employees setting out what would need to be covered in the first day, the first week, and the first four to six weeks. One staff member told us, "For the first two days I had to read care plans and observe care before I started supporting people. I did the care certificate as part of my induction and a senior staff signed it off."

People received adequate food and drink. However, healthy eating was not consistently being promoted; although fresh fruit and vegetables were available people had not been supported to eat a sufficiently healthy diet. Staff members recorded what people ate in weekly record sheets that captured what was offered at each meal time and what the person chose to eat. We selected records for two weeks at random and saw that one person had not been supported to eat healthily. There were several instances where fast food had been eaten and only one occasion recorded where the person had eaten fresh fruit and vegetables. Records for the week commencing 30/01/2017 stated that the person had not eaten healthy food all week. Records for the week commencing 27/02/2017 showed that the person had eaten eight chocolate bars for one meal and toast and chocolate for another meal. Other meals showed that ready-made food such as sausage rolls, 'chicken poppers', pizza and chips and noodles had been eaten. One staff member told us, "We do a meal plan on Sunday evening with X involved. We take it in to consideration; he can change his mind, like tonight." People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. We were told by the deputy manager that a referral had been made to the dietician regarding how to support the person to eat healthily. Despite a referral being made to the dietician there was no record of how staff members had supported the person to make healthier choices or how the person's mental capacity to make unhealthy choices had been assessed. Subsequent to our inspection we were informed by the registered provider that fresh fruit was available to people and that if people ate the fruit it may not be captured in food records.

We recommend that the registered provider seeks nationally reputable guidance on providing nutritious and healthy meals.

People had access to health and social care professionals to meet their needs. Records confirmed people had access to a GP, dentist and an optician, and could attend appointments when required. We reviewed one person's care plan and saw that information had been carried over from their previous care provider. A list of medicines had been handed over with a medical history. A letter had been sent to a local GP to register the person at the local practice and subsequent letters had been sent by the new GP to request referrals to specialist health services. We saw records of health visits such as medicines reviews from the GP, where one medicine had been stopped. In the two months prior to our site visit we saw that five health and social care visits had been recorded. We spoke to staff who were able to tell us about these visits and knew

how to request external assistance from healthcare services.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "They [staff] are caring and they look after you if you have a problem. They sorted out one problem for me with my phone and now I hand my phone in at night."

People received care and support from staff members who had got to know them well. One staff member told us about a person who had requested physical interaction and how they had agreed on a suitable outcome. The staff member told us, "We agreed one hug in the morning, due to issues with personal space, and then we can talk about how he feels." The relationships between staff members and people receiving support demonstrated dignity and respect at all times. We observed good interactions between people and staff who consistently took the time to ask people's permission before intervening or assisting.

Staff knew how to engage people to assist them in their social interactions. Where appropriate, staff were able to use humour to engage people and to sustain conversation, without overstepping boundaries or encouraging increased anxiety in people. Staff members used verbal encouragement to acknowledge the person when they made positive suggestions and remained neutral when they made inappropriate jokes or remarks. This appeared to enable the person to navigate the social interaction with success. We observed two staff members sharing a joke with one person. The person was discussing placing doorbells in the garden and the toilet so that if they were locked out of the house, or locked in the toilet, they could just ring the bell and get help. Both staff members laughed and acknowledged the funny side of this remark. They told the person that they were funny and had a great sense of humour and the person took the compliment with ease.

People were supported to maintain appropriate boundaries with their staff team. On one occasion a staff member reminded the person of the agreed personal boundaries when the person asked them to sit next to them on a small sofa. This was done in a very matter of fact way that took any personal feeling out of the reminder and allowed the person to process the information without experiencing rejection. We observed very natural conversations between two members of staff and one person discussing their plans for the day. After this conversation, during which the person had been put at their ease and they had visibly relaxed, the person requested support with a trip to the seaside and a visit to the library to use the computers.

People were encouraged to make suggestions about their care and support and were both involved in decision making and listened to. One person had been disturbed from their bed when we rang the door for our unannounced inspection visit. The person suggested putting the doorbell alarm near the office near the back of the house so that staff hear it and they do not. This suggestion was encouraged by staff and the person was eager to do the work themselves. One staff member reminded the person that it was their job to do those things but added, "You can help me though if you like?"

People were supported to maintain their independence. One staff member spoke to us about how they encourage people to do things for themselves. Staff described one person's routine and how the person was supposed to have personal care before they have free time. Staff commented, "Today we gave him a few

moments before we reminded him by asking 'what is it you are supposed to do now' and we make it a routine." The person responded by engaging with their personal care. Staff were observed to reinforce any positive views that the person expressed towards themselves. For example, when one person opened up a difficult piece of packaging they declared, "I am strong!" and their staff member replied, "Yes, you are a strong man" in a reassuring manner. The person smiled back at this positive acknowledgment.

People were offered support in a way that was not rushed or time pressured. Support staff were observed to spend a lot of time with one person as they played on a console in a communal lounge. Staff periodically 'checked in' with the person by asking them about the game they were playing and checking they did not have any unmet need, such as requiring another drink. The person was very relaxed with this level of support and verbally confirmed with us that they did not feel pressured or 'left alone'.

Requires Improvement

Is the service responsive?

Our findings

Staff told us that they involved people in their care. One staff member commented, "We ask X to come and join us in staff meetings and give us ideas. He suggested in one that if one staff is in the kitchen with him then no one else should come in as it is too crowded: this was taken on as an idea and implemented." Despite staff involving people in their care we found some elements of care and support that were not responsive.

Care plans were not personalised and did not contain enough information on how to motivate people to engage with their support programme. We reviewed one person's care documents, including documents that were handed over by a previous provider, and found a psychological assessment report. The report was written by a psychologist that had known the person well and had been written within 13 months prior to our inspection. This meant that the information could be used to reliably inform the person's current care plan. The psychological assessment gave a set of recommendations for how to support the person, such as, "Spoken instructions, explanations or information should be given in concrete, simplified language with no more than two items at a time." The report also highlighted how the person benefitted from having visual cues, i.e. pictures or symbols, to aid their memory and that staff should give the person time to think through their response before expecting an answer to any questions. This type of information would be crucial for the person's support as it explained exactly how the person processes information. This is important because if the guidance had been implemented it could enable the person to demonstrate that they have understood a concept or decision. This would then have an impact on their capacity to decide things for themselves, on processing risks, and in sequencing complex pieces of information in stages. If the person is not being supported to understand information in the best possible way they may not be able to achieve important objectives to their full potential. None of this essential information was included in the person's care plan. We also reviewed the person's previous support plan which stated that the first sign of behaviours that challenge was the person being out of their routine. When we checked the PBSP that had been e-mailed to us subsequent to our site visit we found that this information was not included. Furthermore, the new support plan did not contain a description of the person's routine, which meant that staff would not be alerted to possible triggers for behaviours that challenge.

The failure to provide person centred support plans is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests and staff provided support as required. We reviewed the activities plan for one person and saw that there were activities for every day that had been planned, including bowling, cooking sessions, cycling, and pool. One person had been supported to attend a local business where they worked in a shop and did some crafts. One person told us, "Most times I choose to stay home but every Saturday I go out to ice skating. I used to play ice hockey but was injured I play the [gaming console] at home a lot." The person spoke to us about the channels that they followed on a video sharing website related to their favourite computer game.

People had keyworkers. A key worker is a named member of staff that is responsible for ensuring people's care needs are met. This included supporting them with activities and spending time with them. Regular key working sessions were held when staff would discuss the person's week and activities they had engaged with and enjoyed. Some week's people would be offered a reward for positive behaviour, such as buying a new computer game. The meetings provided a time and place where the person could speak openly about their feelings, including negative feelings.

Complaints were not consistently used as a measure to improve the service delivered to people. The service was expected to record all complaints in a complaints log and there was a complaints procedure that set out the difference between formal and informal complaints and the different time scales involved with responding to these. People who made complaints should receive a written response within the timescale set out in the registered provider's policy. There was an accessible complaints policy available for people who may have difficulties with reading the standard complaints procedure. However, we found that no complaints had been recorded. We were told by the deputy manager that no complaints had been received but we had read one complaint in a person's care plan. The complaint was around having their access to their mobile phone restricted (for safety reasons). Subsequent to our site visit we were made aware of another issue where two people had requested that police were called following an altercation. Staff had not called the police and they had not logged people's displeasure as a complaint.

The failure to record, handle and respond to complaints is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The registered manager condition was not being met. When we inspected Edwin Therapeutic Unit there had not been a registered manager in post for 578 days. The last registered manager left in August 2015 and there had been a manager in post who had made an application to be registered with CQC but this was rejected due to a clerical issue. The acting manager had not reapplied for registration and the registered provider had not ensured this happened nor monitored the situation. The acting manager had left the service and a service manager had been employed although they had not applied for registration. A member of staff had been promoted to deputy manager and they had also not applied for registration. The registered provider is required to have a registered manager employed at the service as a condition of their registration. We spoke with the registered provider about the lack of a registered manager at the service and were told that the registered manager from another location was intending to be dual registered to manage both locations. However, at the time of our inspection the manager of the other location had not been registered to manage Edwin Therapeutic Unit. Subsequent to our inspection the registered provider informed us that they were taking action to appoint a registered manager but we had not received an application for registration. This constitutes a breach of the registered provider's condition of registration.

The provider did not have effective systems in place to monitor the quality of care and support that people received. We asked to see the latest set of quality audit reports and were told that quality audits were completed by the service manager. We were provided with some audits, the most recent of these had been completed on 25/04/16 prior to our last inspection visit. The registered provider and the deputy manager confirmed that there had been no more recent quality audits since the audit in April 2016. We asked the registered provider how quality was being checked if audits were not being completed and were told, "I go through care plans with the manager and service manager but I am not sure why we don't have any on file. I'm surprised that it's like that." We asked whether there was any documentation recording when the registered provider had checked through care plans and it was confirmed that there was not. There had been monthly health and safety checks completed, which looked at areas such as first aid boxes, and flooring. Where issues had been identified, such as someone's TV aerial needing to be replaced due to a small cut to the wire, this had been entered on to a maintenance leg. However, the registered provider was unable to demonstrate effective management, oversight and leadership of the service, and was unaware of shortfalls, such as risk assessments being out of date, a legionella assessment being out of date and some safety checks not happening that we identified at this inspection. We asked the registered provider if there was any other evidence that would show a senior management oversight of the service. The registered provider told us, "No."

The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

The registered provider had not notified us of all events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. There were incidents that we were not aware of and had only been made aware of subsequently to our site visit. We schedule inspections against information we receive, so had we been made aware of incidents we may have

inspected the service sooner.

The registered provider had not ensured that the Care Quality Commission had been notified without delay of these incidents. This is a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

In addition to this during the course of our inspection we found that the registered provider had recently placed a person who was previously living at the service in another location that was not registered. The registered provider had not informed CQC of this nor had they made an urgent application for registration as they are required to do. We confirmed that the building was owned by the registered provider and that the person did not have a tenancy agreement signed by the person or on their behalf. We were told by the registered provider, "[service] is supposed to be registered and the paperwork was to be submitted." However the person we believed was living in Edwin Therapeutic Unit had been living in the unregistered service for over three months.

The registered provider did not always keep up to date with current legislation and national guidance. The safeguarding policy in the service was up to date but the advice given around safeguarding to staff by the registered provider was not in line with current guidance. The registered provider had not ensured that care workers had correct guidance to follow when responding to this incident, and several other incidents that met the threshold for safeguarding or criminal investigation. The lack of accurate advice to care workers was also in contravention of the local authority safeguarding adults protocol, policy and guidance. The registered provider demonstrated a lack of understanding of the Health and Social Care Act 2012. For example they were unaware that there is a legal obligation to notify CQC of incidents and of the need to register care services with the CQC.

The culture at the service was friendly and a homely atmosphere was fostered where people could take the lead in their daily lives. We observed one person changing their mind about their activities and their food choices and they felt confident in doing this. One staff member told us, "It's got a lovely homely feel here where everybody feels 'it's your home' and we try and make them feel better and as comfortable as possible in their own home." The registered provider told us, "The staff are committed and we've had changes. Sickness is very minimal and it's positive here: people like to work here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified CQC of all events that had occurred within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to ensure that care plans were person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to adhere to the principles of the Mental Capacity Act 2005 by not ensuring sufficient people were involved in best interest decision making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had failed to record complaints and respond to them appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to provide adequate staff to meet peoples assessed needs

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	Section 33 HSCA Failure to comply with a condition The registered provider was not meeting the conditions of their registration as they had not ensured that the regulated activity, accommodation for persons who require nursing or personal care, is managed by an individual who is registered as a manager in respect of that activity at the service. The registered provider was not meeting the conditions of their registration as they carried on the regulated activity of accommodation for persons who require nursing or personal care from an unregistered location.

The enforcement action we took:

Impose a condition of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to safely manage risks to people.

The enforcement action we took:

Impose a condition of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to make appropriate referrals to the local authorities safeguarding adult's board

The enforcement action we took:

Impose a condition of registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not ensure that quality auditing systems were in place or have sufficient managerial oversight of the service.

The enforcement action we took:

Impose a condition of registration.