Mr Stephen Antony Campbell

The Saltings

Inspection report

7 The Saltings
Littlestone
New Romney
Kent
TN28 8AE

Tel: 01797366216

Date of inspection visit:
10 August 2017
11 August 2017

Date of publication:
15 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 August 2017 and was unannounced.

The Saltings is registered to provide accommodation and personal care for a maximum of three people. There were three people using the service during our inspection; who were living with a range of health and support needs. These included autism, learning disability, epilepsy and other complex conditions.

The Saltings is a detached house situated in Littlestone, Kent. People had their own bedrooms and there was a shared lounge with comfortable seating and TV. A dining area had been set up in the lounge and meals and drinks were prepared in the kitchen.

The service was managed day to day by the provider, who is registered with the CQC. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Saltings was last inspected in February 2017. At that inspection the service was found to require improvement overall with the well-led domain rated as inadequate. We served a Warning Notice on the provider for a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also issued requirement actions for breaches of six further Regulations.

At this inspection the requirements of the Warning Notice had not been met and we found other breaches of Regulation. There had been a lack of robust leadership and oversight to ensure people's safety and the quality of the service. Leadership was lacking and the provider/manager demonstrated that they had neither taken ownership of the issues raised during our last inspection; nor of their own policies.

We identified a number of risks which had not been recognised or addressed by the provider/manager or staff. These included recruitment processes, which remained inadequate in ensuring that suitable staff were employed to work with people. The premises were unsafe for people in some areas but neither the provider/manager nor staff had picked up on the risks and remedied them.

Medicines were not always managed safely and there were no (as needed) medicines PRN protocol in place despite this being raised in our last report. The medicines policy had been updated but was not specific to the service.

Fire drills had not been recorded, but the provider/manager told us they had happened. Accidents and incidents did not always document events accurately and preventative actions had not been properly considered to keep people safe from harm. The provider's safeguarding process had not been consistently followed leaving people exposed to a risk of harm.

The provider/manager and staff lacked knowledge and understanding about the Mental Capacity Act 2005;

and were not always acting within its principles to observe people's rights and choices. Deprivation of Liberty Safeguards had not been sought for people who needed constant staff supervision if they left the service.

There were shortfalls in people's health action plans and a lack of records to evidence health checks, including of people's weight. People for whom a fortified diet had been recommended did not receive meals with any extra calorific value than other people on 'normal' diets.

Behaviours were not assessed, monitored or managed appropriately to ensure people and others were kept safe. Staff training was inadequate and exposed people to risk because staff worked alone without the necessary knowledge to support some people's conditions.

Care plans were not consistently person-centred and had not always been updated to show current information. Activities required further input for one person, to ensure they received sufficient social stimulation.

Records about complaints did not include information about investigations or outcomes. Auditing processes had been largely ineffective in highlighting areas of the service that were unsafe or required action to improve quality.

Personal emergency evacuation plans had been improved since our last inspection and the provider/manager now had a business continuity plan in place. Safety checks had been carried out on gas and electrical supplies. The service was clean and fresh, but no deep-cleans had been scheduled.

The provider/manager and staff were kind and caring towards people. We observed only gentle and considerate interactions and people appeared comfortable and relaxed with staff. There were enough staff deployed to meet people's needs.

We found a number of breaches and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Recruitment processes were not sufficiently robust to ensure the suitability of staff employed in the service

The environment was not safe for people in a number of areas and fire drills had not been documented.

Medicines were not always safely managed.

People had not been consistently protected from abuse or harm because safeguarding processes were not always followed.

There were enough staff deployed to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The provider did not have a good understanding of the Mental Capacity Act and was not working within the principles of the Act.

Health action plans were incomplete and important instructions were not followed.

People's nutritional needs were not clearly understood or met by staff.

Staff induction training was incomplete and some staff had not received required training.

Staff felt supported by the manager, but supervision meetings were not always completed when planned.

Is the service caring?

Requires Improvement

The service did not consistently demonstrate caring.

People's safety and well-being had not always been considered.

Staff and the provider/manager interacted with people in a kind

and patient way.

People were encouraged to be independent where possible and were involved in day to day decisions about their support.

End of life wishes were documented where known.

Is the service responsive?

Requires Improvement

The service was not sufficiently responsive.

Care plans lacked detail about people's individual personalities and did not always provide accurate of up to date information about people's care and support needs.

There was an easy to read complaints form for people to use if they wished but there was no proper recording of complaints, investigations or outcomes.

Some people engaged in more activity than others. Social stimulation could be improved for one person.

Is the service well-led?

Inadequate

The service was not well led.

The provider/manager lacked oversight of the service and ownership of previously identified shortfalls.

Quality assurance checks were ineffective or not completed.

The provider did not always notify the Commission of incidents, or display their last inspection rating, both of which they were legally obliged to do.

The Saltings

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This inspection took place on 10 and 11 August 2017 and was unannounced. Two inspectors carried out the inspection.

Before our last inspection, we asked the provider to complete 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 did not ask the provider to complete another PIR prior to this inspection. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which 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.

We met with all three of the people who lived at The Saltings. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We looked at the environment including the bathrooms and people's bedrooms. We spoke with staff and the registered provider/manager.

We 'pathway tracked' all three people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People were unable to tell us about their experiences of being supported at The Saltings. However, we observed that they were relaxed and appeared comfortable around staff and the provider/manager.

Despite this, our findings showed that the service was not consistently safe for people living there.

At our last inspection people had not been protected by robust recruitment procedures. At this inspection the situation had not improved. There continued to be unexplained gaps in staff's employment history, which had not been explored by the provider/manager, so that a full picture of what staff had been doing in the past was clear. The reference for one staff member gave different dates that they were employed than on the application form they submitted; but this had not been noticed or followed up by the provider/manager. Two staff were working without proper checks made through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider/manager had made applications for criminal records checks to another body, but these were not sufficiently detailed to provide assurance that staff were suitable for their roles; and in any case had not been received before staff started work in the service.

The failure to operate a robust recruitment procedure is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection no fire drill had been conducted to check that staff and people could safely evacuate the premises in the event of an emergency. At this inspection the provider/manager told us that fire drills had happened but there were no records to document when these had taken place, who had taken part and what the outcome was. This was important so that any learning points from carrying out the drills could be actioned and improved.

The premises and grounds were not in a safe condition for people. The door to a downstairs room was wedged open and several blades for a cutting tool were spread across the inside window sill. A hammer and large pair of scissors were in a tray on the floor with other tools such as wallpaper scrapers. A bucket of made-up wallpaper paste and a small set of steps were also in the room unattended. All of these items posed a serious risk to people living in the service and we advised the provider/manager to make the room safe by locking it immediately; which they did. The provider/manager told us that people would not go into this room, but we later saw that one person did try to enter it.

A shed in the garden contained a large amount of building materials and other items that were stacked high. Bottles of weed killer, white spirit and strong glue were accessible just inside the door; which was unlocked and open. There was a risk that people might touch or swallow these chemicals or that they could injure themselves on other items in the shed. We advised the provider/manager to secure the shed and they told us they had done so. However, when we checked it again later we found that the door was shut but there was only a broken padlock in place We made the provider/manager aware that the door needed to be

properly locked

Some upstairs windows did not have proper restrictors in place to prevent them from opening wide. Incident reports showed that one person had climbed out of their bed over bed sides, and their bed was positioned directly below an unrestricted window. We told the provider about this and they assured us that the windows would be restricted as a matter of urgency. Following the inspection the provider contacted us to confirm that restrictors were now in place.

The failure to operate a safe environment is a continued breach of Regulation 12 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal emergency evacuation plans now contained more detail about how to support people to leave the building in an emergency. The provider had introduced a business continuity plan so that people would continue to receive support in emergency situations. This included evacuation to a local holiday park where people could be supported until more permanent arrangements could be made.

Safety checks had been made on gas and electrical systems in the service. Fire alarms had been tested monthly and emergency lighting and fire-fighting equipment had been regularly checked. A carbon monoxide alarm had been tested each month to ensure that it was working efficiently.

At our last inspection, medicines had not been managed safely. At this inspection there was little improvement. There were still no protocols in place for people who had medicines prescribed to them on a 'when needed' (PRN) basis. These should document the name and type of medicine, why it had been prescribed, how often it could be taken and minimum time gaps between doses. The provider/manager did not understand what was meant by a PRN protocol when we spoke with them and showed us the directions on a box of PRN pain relief. However, the provider's medicines policy stated that protocols must be in place for all PRN medicines. It was concerning that the provider/manager did not know or follow the contents of their own policy.

At our last inspection the provider's medicine policy had not been regularly updated and was not specific to the service. At this inspection the medicines policy had been changed and was now dated 2017. However, the policy was a general template and not specific to the service. It was headed up 'Anonymous Care Ltd' and in many areas had not been completed to show correct details of the service or staff. Policies are intended to give guidance to staff about how the service should be run, but there had been no ownership of the policy by the provider/manager.

The failure to manage medicines safely is a continued breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, assessments had not been made to show how people might express pain. At this inspection, the provider/manager told us that two people could verbally say if they were in pain or discomfort. However, care plans did not record this information. A third person's care plan said that the person would remove their spectacles and rub their face if they were in pain. Staff on duty were able to tell us this too. However, we noticed that the person was not wearing spectacles throughout the inspection, so it would be more difficult for staff to pick up cues about pain. The information in this person's care plan was not sufficiently detailed to ensure that staff would be alerted to pain at times when the person was not wearing spectacles. This is an area for improvement.

Medicines administration records (MAR) showed that people had received their regular medicines as

prescribed for them. Assessments were now in place about any risks to people associated with medicines and their administration.

At our last inspection, accidents and incidents had not been well-managed or monitored for trends. At this inspection there had been no improvement. For example; an incident report for one person recorded that they had fallen on the floor 'When climbing out of bed'. Later in the inspection we established that this person had fallen when climbing over bed sides. They would have fallen from a greater height than suggested by the incident report; which did not give an accurate picture of what had happened. Following the incident the bed sides were removed and the provider/manager told us that sleep-night staff shifts had been changed to wake night ones so that regular checks could be made on this person. The provider/manager said that they had made this change so that staff could hear quickly if the person fell. However, there were no preventative measures in place to stop the person hurting themselves if they fell from bed or to prevent them from falling out of bed; such as lowering the bed or placing a special mattress alongside to create a softer landing should they fall.

The failure to assess and appropriately mitigate risks to people is a breach of Regulation 12 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not always been kept safe from abuse or harm because the provider's safeguarding system had not been consistently followed. At our last inspection there were no proper strategies in place to support people who showed specific behaviours. At this inspection we became aware of one person's behaviour on arrival and we asked the provider/manager if this ever caused any difficulties either inside or outside the service. They replied that it did not but we later heard about an incident involving this behaviour when the person had fallen as a result. There was no assessment in place about the risks to either the person or to others and no record of any actions taken to reduce the risks. The provider's policy about challenging behaviour stated that 'A full and robust risk assessment must be undertaken', but this had not happened. The provider/manager told us that the incident had not been discussed with the local authority safeguarding team; and the CQC were not notified of it.

At our last inspection, the provider's safeguarding policy had not been updated to include current information and contacts. At this inspection the policy had been reviewed and now included the proper details. However, the provider/manager and staff had not followed the policy in respect of the incident where the person fell as result of a behavioural event.

The failure to take appropriate actions to protect people from abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we highlighted that some areas of the service needed a deep-clean. At this inspection the service was found to be clean and fresh and there was a schedule in place for staff to follow for daily cleaning tasks. However, there was still no deep-cleaning schedule in operation to identify which areas or equipment needed a more intensive clean; and how often. This is an area for further improvement.

There were enough staff on duty to meet people's needs. A dependency scoring tool was in place for each person. These are generally used to work out how much support people need and this information is used to determine staffing levels. However, the scores had not been totalled up and there was no clear rationale to show how these were used to inform decisions about how many staff were needed. This is an area for improvement.

There was one staff working during the day and one wake staff on duty overnight. Rotas showed that these

levels had remained consistent in the weeks leading to our inspection. The provider/manager and staff from the provider's other service were used to drive people to day centres or activities and appointments, so there was always staff remaining in the service to support people who did not go out. During the inspection staff spent time with individual people and any needs were met promptly.

Inadequate

Is the service effective?

Our findings

At our last inspection people's rights were not protected under the provisions of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection we checked whether the service was working within the principles of the MCA and found they were not; many of the concerns identified at our last inspection remained unaddressed. The provider/manager did not have a good understanding of the process needed to comply with the MCA and was not working within its principles. People's capacity had not been assessed to see if they were able to make decisions themselves, for example, about staff administering their medicine, dealing with some day to day finances and whether people could safely leave the service without supervision of staff when outside.

If people are assessed as lacking capacity any action taken or any decision made for or on behalf of that person, must be made in their best interests. The people making these decisions normally include the care provider responsible for day-to-day care and a professional such as a doctor, nurse or social worker where decisions are about treatment, care arrangements or accommodation. Where appointed, a legal power of attorney for health and welfare matters should be involved in decision making. Best interest processes had not been followed for one person to determine if a restriction decided upon was the best and least restrictive option; meetings had taken place without health or social care professionals being invited. Subsequently, the restriction imposed had been removed because the person suffered a fall trying to get around it.

Where a best interest decision is made and a restriction imposed, they must be legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). Restrictions can include rails intended to keep people safely in bed and not allowing people to leave the service without the constant supervision of staff. Discussion with staff and the provider/manager found a DoLS application had been made for one person; however, it made no reference to the use of bed rails that were in place for the person. Additionally, applications had not been made for two other people who we were told were unable to leave the service without constant supervision of staff.

The failure to act in accordance with the requirements of the Mental Capacity Act 2005 is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we highlighted that although people each had a health action plan and hospital passport, some of this information was not up to date and did not give staff enough detail to consistently support people. At this inspection there were similar shortfalls. A health care worker had visited one person and noted in the care plan that the person had sore, red areas of skin and that cream should be applied to these areas. A body map present in the care plan was incomplete; it did not show where the cream should

be applied or give any guidance about how and when it should be applied, or what to do if the skin remained inflamed. Records of daily care did not make reference to the application of this skin cream and there were no comments about the condition of the person's skin or that checks had been made.

Another person had received a letter from their GP inviting them to the surgery for an annual health check and blood test; the letter was dated 20 June 2017. On 20 July the GP sent a reminder as no appointment had been made. We subsequently found the service had booked an appointment for the person on 19 September, three months after the GP's initial contact. Examination of health care plans and discussion with the provider/manager could not determine when dental check-ups or blood pressure monitoring had last taken place for one person.

A visiting health care worker had visually noted one person looked underweight, they recommended the person should be weighed regularly and their weight monitored. Their health action plan showed they were weighed once, immediately following the recommendation. Since then, in the subsequent months, no further weight had been recorded. It was not possible for staff to determine if the person had gained or lost weight and if further action was needed. Weight records for other people were also not up to date.

One person demonstrated a behaviour which could potentially be unwelcome to those experiencing it. This occurred within the service, at day centres and potentially public places. There was no behaviour management plan in place. Although staff spoken with were aware of the behaviour and trigger, there was no guidance to enable staff to consistently support the person, no strategy to reduce the behaviour, or evaluation following incidents. When the person visited their day centre, there was no written information to ensure supervising staff were aware of their behaviour or how it should be managed.

The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. This is a continued breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the day staff offered people a choice of hot or cold drinks; some people helped staff in the kitchen making and icing cakes, doing the washing up and preparing drinks. People told us staff asked them what they wanted to eat and the menu was formed around this. However, we found a health care professional had recommended that one person should be provided with fortified meals because of concerns around the risk of weight loss. Discussion with staff found they had little understanding of what was meant by fortified food; this is the addition of protein, fat, and/or carbohydrates to foods, for example, full fat milk, butter, cream, cheese. We observed lunch on both days of the inspection and spoke with staff; there was no difference in the food between those who needed a fortified diet and those who did not, placing the person at risk of weight loss

The provider had failed to ensure the nutritional needs of people were met. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a member of staff, who had recently started work at the service, about the training they had received. We also looked at the staff training matrix for all of the staff who worked at the service. Induction training took place over two weeks where new staff shadowed experienced staff to get to know the service and the people they supported. Mandatory training included;
safeguarding, fire, first aid, moving and handling, food hygiene, medication, health and safety, and infection control. We looked at the personnel file for one member of staff, their induction training checklist was blank; nothing had been completed to record the training completed. They told us they had watched some training DVDs, but no training had been delivered in person. No competency assessments were made to

check if the member of staff had the skills and knowledge needed to safely support people. The same member of staff had routinely worked unsupervised, covering day and night shifts. One person's risk assessment stated that staff supporting them must have received epilepsy training. The training record for the member of staff on duty on the first day of our inspection and four other staff showed they had not received epilepsy training. Discussion with the provider/manager confirmed this.

The provider had failed to ensure staff had received appropriate training to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Discussion with one member of staff found they felt supported by the provider/manager; they had received informal chats about how they were getting on, however, this was not recorded. Discussion with the provider/manager found a staff supervision plan was in place, there were records of some supervision meetings; however some of the supervision meetings had not taken place when planned. There was a plan in place to address this. This is an area identified as requiring improvement.

Throughout the inspection we observed staff offering people choices and asking for their consent before supporting them. People told us, "This was usual."

Requires Improvement

Is the service caring?

Our findings

The service was not consistently caring. Although we observed only kind and caring interactions between staff and the provider/manager and people, concern for people's well-being was not always demonstrated in a meaningful way.

Areas of the premises had not been kept safe for people, so they were exposed to risk of harm. One downstairs room was being decorated as a prospective bedroom when we inspected, and the provider/manager had taken care to choose bright and welcoming décor. An en-suite bathroom had been fully fitted out to provide comfortable and accessible facilities adjacent to the bedroom. However, the tools and equipment being used to decorate had been left over the floor and surfaces, and the room was unlocked and accessible to people.

The garden shed was unlocked and contained harmful chemicals that people could reach; and some upstairs windows could be opened wide because they did not have appropriate restrictors on them. All of these areas posed risks to the safety and well-being of people. This did not evidence that good care was taken of people and the issues should have been identified and put right by staff and the provider/manager before inspectors highlighted them.

Staff and the provider/manager spoke to people respectfully and listened to them when they wanted to speak. One staff sat with a person while they listened to their favourite music and talked about the artists and the instruments. They were patient and well-meaning; trying to distract the person when some songs made them emotional. There was a comfortable and affectionate atmosphere in the service; people moved about as they wished but staff were on hand to support them when needed. People presented themselves smartly in clean and appropriate clothing and one person showed us how they shaved themselves each day with a battery-powered razor.

One person helped staff to make cakes for everyone on one afternoon. The person was animated when telling us about the cakes and clearly enjoyed the experience and staff attention. People were encouraged to be independent where at all possible. For example, one person offered inspectors a warm drink and then served them. Another person's care plan set out the ways in which staff could promote independence, for example, by encouraging the person to draw their own bedroom curtains at night.

People's private information was stored securely and kept confidential by the provider/manager and staff. They were careful to only talk about people's care and support arrangements in private and care plans were kept in the office. Staff showed respect for people by calling them by their preferred names but referring to them as' Mr [Surname]' when speaking with inspectors about those people. Staff discretely prompted people about using the toilet and knocked on bedroom and toilet doors before entering.

People had been involved in decisions about their support wherever possible. Staff meeting minutes recorded that some menu items had been changed because people had expressed that they did not enjoy them. Staff asked people what they would like to eat and gave them choices. We saw that consent to a

certain aspect of care had been signed by one person. Information about advocacy services was available and in easy to read format. The provider/manager and staff said that relatives were welcome to visit people at any time and surveys completed by families confirmed this.

End of life wishes had been documented so that people's choices could be respected when the time came.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, care plans were not sufficiently detailed to ensure people received appropriate support. Some information within care files was inaccurate or had not been kept up to date. At this inspection there had been little improvement in this area.

There was minimal information in care plans about people's individual personalities; although people's preferences had been documented for food and drinks and times to get up and go to bed. During the two days of our inspection we learned about people's characters through our interaction and observation, but care plans did not adequately reflect people's personal qualities or natures. There was no information about people's individual goals and aspirations and how these were being worked towards.

Care plans and risk assessments had not been updated to show current information or guidance in a number of cases. This created a risk that staff would not know how to support people appropriately. For example; two people's care plans about looking after their skin had not been updated after new redness was noted by staff. The daily diary for these people did not record the sore skin and there was no mention of it in the diary on the following days. Falls risk assessments did not include details of the most recent falls or any actions taken to reduce the likelihood of recurrence. Some assessments did not reach any conclusions about risks to people and were not followed through with information about preventing impact upon people from those risks.

Although no agency staff were used by the provider, some staff had been working in the service for a short period and worked alone during the days or nights. It was important that they had current, accurate information and guidance to help them support people.

The failure to design care and treatment with a view to meeting people's needs and preferences is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained family tree diagrams entitled 'Who is in my life', to show the names and relationships of friends and relatives who were important to people. Some care plans were more specific than others. For example, one care plan about communication gave step by step guidance about how to engage the person and suggested conversation topics based on the person's hobbies.

People had received help to make complaints when they wished to. The provider had complaints forms in an easy to read format, with pictures to illustrate how the complaints process worked. We read a complaint made by one person which detailed their concerns but there was no record about how the complaint had been investigated or resolved. The provider/manager told us what had happened, but said that there was no complaints book or file to document the progress of any complaints made.

The provider had a complaints policy in place which had been updated in May 2017. This stated that details of all complaints would be recorded in the complaints book, the persons' care file and in records held by the

service. This had not happened and showed that the provider did not operate a robust complaints process.

The lack of an effective complaints process is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People engaged in a variety of activities. These included monthly discos and bi-annual holidays away from the service that were organised by the provider/manager. Two people went to a craft centre three times a week and one person liked to grow vegetables in planters in the garden at the service. During the inspection, another person watched music videos and made cakes with support staff. The provider/manager told us that people often met up with those living and working at their other service and spent leisure time together.

A further person either slept or watched TV throughout our inspection. Their care plan about activities and hobbies recorded that they needed full support of staff to engage in these and that staff should encourage regular activity. The provider/manager told us that this person liked to go out in the car to collect the other people from the craft centre and to be involved in the weekly shop for the service .However; day to day personalised social stimulation was limited for this person. Staff meeting minutes from June 2017 highlighted that people were not going out enough or doing any activities. A new activities rota had been put into place following that meeting but this remains an area for further improvement.

Inadequate

Is the service well-led?

Our findings

In discussion with the provider/ manager, they told us, "My paperwork is lax, I do my best, but I always put the guys first." Staff told us the provider/manager, "Cares deeply about each person, I can say with hand on heart, he always does his best for them."

Our last inspection found the lack of oversight by the provider/manager had negatively impacted on the safety and quality of the service. At this inspection no improvement had been made; the service previously rated as Requires Improvement had declined to Inadequate.

Concerns previously identified remained unaddressed. For example, recruitment checks remained inadequate, regular fire drills were not completed, aspects of care plans were not up to date and care was not planned or delivered in a way to ensure people's safety or that their needs were met. Concerns about the safety of the premises and garden were not recognised, assessed or addressed and incidents and accidents were not properly recorded or effectively monitored. The provider/manager had failed to take ownership of identified concerns or develop effective systems to drive through the improvement needed.

Leadership was lacking at the service and significant improvements were needed to ensure people's needs were safely and consistently met. The provider/manager relied on help from the local authority to develop care plans and staff to update them and implement a quality framework. The provider/manager did not carry out their own quality assurance checks or competency checks of staff to assess the quality and safety of care delivered. The provider/manager did not take ownership or demonstrate an understanding about the importance of keeping up to date and accurate records, or ensuring instructions from health care professionals were always put into practice. This impacted on the health, safety, care and support people received.

With the exception of audits of care plans and medicines, completed by other staff, there were no reliable systems to provide oversight of accidents and incidents, risk assessments, health and safety or fire safety. All of these areas were found lacking during this inspection. For example, the health and safety audit carried out by staff did not include checking that window openings were properly restricted or that chemicals in the shed were locked away. The provider/manager did not demonstrate the knowledge or qualities required to recognise risk or safely manage the service.

We were shown the provider/manager had previously distributed questionnaires to seek feedback from people and relatives to improve the service. However, these predated the last inspection and, since then, no further feedback had been sought.

The provider had failed to identify shortfalls or establish systems of regular effective auditing. The provider had not maintained accurate, complete and contemporaneous records. The provider had failed to seek and act on stakeholders views. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to notify the Commission (CQC) of certain events at the service. Records showed although an incident of suspected abuse had been appropriately reported to the local authority and the police, the provider/manager had failed to notify CQC of the incident. This is a requirement of their registration and helps CQC monitor events in services.

The failure to notify the CQC of incidents of suspected abuse or harm was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider failed to display their current ratings at all; people visiting the service were unable to view it. We have taken further action against the provider in respect of this.

The provider had failed to display their latest CQC inspection report ratings at the premises which the service provides regulated activities. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.