Mrs J & Mr H Chamberlain & Mrs N Woolston & Mr D Chamberlain & Mr Thomas Beales

Grove Villa Care

Inspection report

24 Mill Road
Deal
Kent
CT14 9AD

Tel: 01304364454

Date of inspection visit:
20 April 2017

Date of publication:
25 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 20 April 2017 and was unannounced.

Grove Villa is a large detached house in a quiet residential area, it shares a site with two other services owned by the same provider. It provides care and support for up to 16 people, with a learning disability. There were 16 people living at the service when we visited.

There is a registered manager working at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The providers changed to a limited company in April 2016.

The culture of the service, was one that staff 'did for' people rather than 'with them', which is in contrary to best practice when supporting people with learning disabilities and meant people did not learn and develop.

People were not involved in developing and updating their care plans. People's care plans were not always person centred and some contained inaccurate information. Staff knew people well, some interactions between people and staff positive but people with more complex support needs had limited interaction from the staff. People were not always treated with dignity and respect, the language used to describe people was not always respectful and indicated that staff were in control of the environment instead of people. For example staff described people as being rude and told one person to return to bed as it was too early to get up.

There was a board in the dining room letting people know what activities were happening each day; however this was not being used so people did not know what was on offer. Staff had been advised to use communication tools with some people but this was not happening.

Some people attended local day services and took part in other activities they enjoyed. Other people who had more complex support needs or who could show behaviours which could challenge had limited opportunities to take part in activities or go out and about. Some people had not left the service, except to attend medical appointments for several months. There were no goals recorded for people or plans to help people reach their goals or develop new skills.

People told us they felt safe at the service. Staff told us about different types of abuse and said they would report any concerns to the registered manager or the Care Quality Commission. However, we found six incidents had been recorded, which were potentially abusive. The registered manager said they were unaware of the incidents and had not reported them to the local safeguarding team. We asked the registered manager to speak with the local duty team at social services to discuss these issues, and they

contacted them whilst we were there.

Some risks to people were identified, however one person did not have a risk assessment around choking despite this being highlighted by the local community team as a risk. Some risk assessments gave staff the guidance needed to manage and minimise the risks, but others did not. People did not have personal emergency evacuation plans to detail what support they needed to leave the premises in an emergency such as a fire. Risks to the environment were assessed and managed safely.

People's medicines were not always managed safely. Staff signed medicines records before giving medicines to people and did not always have the guidance needed around the use of 'as and when required' medicines. People were not always given emergency medicines in line with guidance from a health care professional.

Most staff were recruited safely, however one staff member did not have any references on file. Staff had induction training and were introduced to people by established staff before supporting them. Staff completed basic training; however further training was required to meet people's needs. Staff had regular one to one meetings, but appraisals had not been completed. There were enough staff to keep people safe, but staff told us there were not always enough staff to support people's activities. Staff told us they felt supported by the registered manager and deputy manager.

Some people were not fully involved in choosing what they wanted to eat each day. When people were at risk of losing weight they were referred to a nutritionist and any guidance put in place was followed by staff.

People had access to healthcare professionals when required and any concerns about people's health were responded to quickly. However, staff did not always have the guidance needed to support people to manage their long term health conditions.

Staff had some understanding of the Mental Capacity Act 2005 (MCA.) However, some people did not have capacity assessments in place to assess if they could make individual decisions. Some people had had procedures such as flu vaccinations, without their capacity being assessed or a best interest decision being made. Some people's care plans stated they lacked capacity in some areas, but daily records showed, they were making decisions on a regular basis. There was a risk decisions could be made for people when they were, in fact, able to decide for themselves.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager had applied for DoLS for people when their liberty was restricted and some of these had been authorised. However, on the day of the inspection they could not tell us who had a DoLS in place and who did not. They sent us this information after the inspection.

The registered manager was accessible to people, professionals and staff. However, the registered manager did not have a plan to develop or maintain their skills. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager had not submitted notifications, in a timely manner. Audits were completed but had not identified the issues found at this inspection. There was a complaints procedure in place, which was in an accessible format. No complaints had been received since the change in provider in April 2016.

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

2014.You can see what action we told the provider to take at the back of the full version of the report.

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.

Potentially abusive incidents had occurred which had not been referred to the local authority safeguarding team.

Risks to people were not always assessed or mitigated. The environment was safe.

People's medicines were not always managed safely. There was a lack of guidance for the use of 'as and when required' medicines and people did not always receive emergency medicines in line with guidance.

There were enough staff to keep people safe. Most staff were recruited safely but one person did not have any references in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not have all the training required to meet people's needs.

Staff understanding of the principles of the Mental Capacity Act was limited. Staff had made decisions for people without assessing their capacity to make the decision for themselves.

Staff did not always have the guidance needed to manage risks relating to people's health. People were supported to access health care when needed.

Some people were given a choice of the food they ate, but others were not supported to choose. People were supported eat and drink safely.

Is the service caring?

Inadequate

The service was not caring.

Staff spoke with and engaged with some people but not with

everyone
Staff did things for people, rather than with them. People did not have the communication tools they needed to make themselves understood.

The language used by staff to describe people was not always respectful.

Is the service responsive?

Inadequate

The service was not responsive.

People's care was not always personalised to their individual needs. People's care plans were written without their involvement and some were inaccurate.

Some people took part in regular activities and outings but people with more complex needs had very limited access to activities and did not go out on a regular basis.

There was an accessible complaints procedure for some people and some people knew who to complain to. There were no systems for people with more complex needs to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

Staff appeared to care about people, but there was not always a person centred culture.

Staff told us they felt supported by the registered manager; however they required additional support and training to carry out their roles. Notifications to CQC had not been submitted in a timely manner.

There was a lack of oversight by the provider. Audits were completed but these had not identified the issues identified at this inspection.

People, staff, relatives and other stakeholders had been asked their views of the service.

Grove Villa Care

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 20 April 2017 and was unannounced. The inspection was carried out by two inspectors.

We did not ask the provider to complete a Provider Information Return (PIR), as we carried out this inspection earlier than expected. A PIR 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 reviewed information we held about the service. We looked at notifications received by the Care Quality Commission (CQC). A notification is information about important events which the provider is required to send us by law, such as a serious injury.

During the inspection we spoke with three people, the registered manager, a senior support worker and two members of staff. We observed staff supporting people. Some people were not able to explain their experiences of living at the service to us so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at documents including four care plans, medicines records, four staff files, risk assessments, audits, minutes of meetings for people and staff, training records and staff rotas.

This is the first inspection of this service since a change in provider in April 2016. The providers are the same people but changed to a limited company last year.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. Staff told us they kept people safe and understood who to report any concerns to. One said, "I know the types of abuse that happen and who to talk to about it." However, we found that staff had not recognised and reported abuse appropriately and we found issues and concerns about people's safety.

Six incidents had been recorded which involved people in potentially abusive situations. These were detailed on incident forms that had been filed by the deputy manager and no further action had been taken. Staff and the registered manager had not followed the provider's safeguarding procedures by consulting with the local authority safeguarding team who would have discussed the incidents. A decision would then have been made on how to proceed to keep people safe in the way that suited them best. Staff had not recognised that these incidents were potential abuse and had not reported them. We asked the registered manager to speak with the local duty team to discuss these issues, and they contacted them whilst we were there. The registered manager was asked to send details of the incidents to people's care managers. They confirmed they had done this after the inspection.

Staff and the registered manager were not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. People were not fully protected from abuse and the registered manager had not followed the correct procedures to make sure people were as safe as possible. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had identified some of the risks associated with people's care, such as mobility and eating and drinking. Some care plans explained how to manage these risks and ensure that people received the care they needed to minimise the risks from occurring. However, one person was at risk of choking and had been supported by the local community team to assess the risks. Despite this support, there was no guidance in their care plan or risk assessments for staff about how to minimise this risk. There had been no incidents of choking recorded. Staff told us, "We support some people who can choke if they have the wrong food or consistency. I would follow their risk assessments." However, the risk assessment did not give staff the guidance they needed.

Other risks to people, including epilepsy, were not assessed fully. One person's care plan contained basic information about the emergency medicine they needed to take if they had a seizure, but not what their seizures looked like or how often they occurred. Staff had documented that the person would sometimes, 'fake a seizure.' There was no information regarding how to differentiate between a 'fake seizure' and a 'real seizure.' Staff told us it could be, "Very hard" to tell the difference between the two. The registered manager told us that if you 'tickled' the person you could usually tell if the seizure was real by the person's reaction and another staff member told us that the person, "Will look your way if they are faking," this information had not been shared with the entire staff team and was not recorded in the person's care plan or risk assessment. There was a risk that the person would not get the right support when having a seizure.

There had been occasions when people displayed behaviours that may challenge. There was risk that they may hurt themselves or other people. There were no step by step guidelines in place to explain to staff how to support people in a way that suited them best. Staff had identified some specific behaviours such as, '[The person] can become agitated and distressed which leads them to shout and sometimes throw themselves on the floor' and triggers for behaviours, such as 'staff/clients unable to understand them.' However, there was a lack of information on how staff should respond to these situations so that the support was consistent.

People's care plans stated staff should 'divert' people's attention to prevent 'unacceptable' behaviour, yet there was no information on how to divert people's attention or the most effective means of doing so. Staff had not received training in positive behaviour support so did not have the knowledge or skills on how to respond to these situations. There was a risk that staff would be inconsistent in their approach to these situations and the risk would not be reduced. Some people had displayed behaviours that challenged and people had been hurt as a result.

When people did display behaviour that challenged this was documented on an incident form. However, these were not collated or analysed to look for any trends or patterns or ways of reducing the risk of the behaviour occurring again. The completed forms were consistently filed by the deputy manager without the registered manager reviewing them.

People did not have personal emergency evacuation plans (PEEPs) in place. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency.

Medicines were not always managed safely. Staff should only sign a medication administration record (MAR) when a person has taken their medicine. When staff assisted people with their medicines they signed their medication administration record to say the medicine had been administered and taken before people had actually taken their medicines.

Some people were prescribed medicine on an 'as and when needed' basis for pain relief or anxiety (PRN). There was guidance in place for when some of these medicines should be administered. However, this was inconsistent and for some medicines there was no guidance in place at all. For example, one person was prescribed a medicine to help them sleep at night if they were distressed or anxious. There was no guidance for staff relating to this medicine. The medicine had been administered on 8 April 2017 and 19 April 2017 but staff and the registered manager were unable to tell us why the medicine had been administered. The person's daily notes indicated they had been settled and staff had not completed any incident forms relating to the person's behaviour on these dates. There was a risk this person had been given this medicine unnecessarily.

One person was prescribed emergency medicine to stop a seizure. There was guidance in place from a healthcare professional that stated their medicine should be administered, 'at the beginning of a third briefer seizure.' Staff were not consistently following these guidelines and on seven occasions between January and April 2017 staff had administered the medicine after the fourth of fifth time the person had experienced a 'briefer' seizure. The registered manager told us that they regularly checked people's medicines but did not check when staff had administered this medicine and they were unaware that staff were not following the person's guidelines.

Staff did not routinely date medicines with a shorter shelf life when they opened them and there was a risk people's medicines may not work effectively if they had been opened for too long. One person was

prescribed two different types of eye drops that should be discarded, '28 days after opening.' Staff had not documented when these eye drops had been opened so there was no way of checking that they were still safe to be administered. Staff had not dated bottles of other liquid medicine such as lactulose on opening.

Risks relating to people's care and support were not always adequately assessed or mitigated. Medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff to keep people safe, but not always enough staff to meet people's needs. Some staff said it would be helpful to have additional staff to help people go out or do activities. Sickness and holidays were covered by the staff team and, if needed, the deputy manager and registered manager stepped in. Staff told us, "We are a good team and generally if we need cover someone will come in. Sometimes it would be good to have extra staff to get people out and about but we can meet people's needs in the house with the staff we have." There were times during the day when we observed that there was a lack of staff interaction with people. Some people were waiting for a member of staff to return so they could go out, one person required staff to reassure them as they became agitated whilst waiting.

Most staff were recruited safely, however, one member of staff did not have any references in their recruitment file. The registered manager told us that this person had just left school and was related to the provider. They told us the provider had given a reference for this person. The provider's policy for recruitment said staff should have two references. We recommend the provider adhere to their recruitment policy.

Staff carried out regular health and safety checks of the environment and equipment to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. Water temperatures were checked to make sure people were not at risk of getting scalded. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly.

Requires Improvement

Is the service effective?

Our findings

People looked happy with their meals and some people sat together to eat. Staff gave some people choices about what they wanted to do and asked if they wanted to take part in the music activity in the afternoon.

Staff completed induction training which included completing the care certificate which is a set of standards care staff can achieve. Staff also worked alongside experienced staff to get to know people and establish relationships with them before supporting them alone.

There was a basic training programme in place for all staff. After staff completed training their knowledge and competency was assessed during one to one meetings and through observations while supporting people by the registered manager and senior staff. Training included basic training such as safeguarding and fire awareness. Staff also completed training related to people's needs such as epilepsy awareness.

Staff did not have an understanding of best practice when supporting people with learning disabilities including person centred support or positive behaviour support. These subjects are important for staff to have an awareness of if they are supporting people with learning disabilities. Staff had not completed any training related to supporting people to develop and work towards personal goals including person centred planning.

Some staff were confident about supporting people with behaviours which could challenge, one told us, "There is always a reason, if you can't find out what it is you need try and distract the person with something they like." Other staff were not so confident and told us they would follow the care plans or call for other staff. However, not all care plans contained step by step guidance about how to support people when they were angry or upset. Staff had not all had training about the best ways to support people with learning disabilities who may get anxious or angry. The registered manager told us that some staff would not take some people out as they could display behaviours which challenged. This had restricted some people from going out.

Although staff had attended training in safeguarding people and mental capacity, this was not being put into practice. For example, possible abusive incidents had not being recognised as a safeguarding concern, people were not being involved in planning their own care and decisions were being made for people who may have the capacity to make them for themselves. The registered manager told us they would be arranging refresher training for staff in these areas as soon as possible.

Staff had team meetings and regular one to one meetings with their supervisor to talk about any issues, and their own development. Staff had not had appraisals to plan their development and review their performance for the year. Appraisals would give staff an opportunity to identify any training needs or areas where they needed support.

Staff could contact the registered manager or deputy manager at any time for support through an on call system. Staff said they felt supported by the registered manager.

The provider had not ensured that staff had all the training they required to meet people's needs, support them consistently and keep them safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager had applied for DoLS for people when their liberty was restricted and some of these had been authorised. However, the Care Quality Commission had not been notified when people's DoLS had been authorised, as required by law. We asked the registered manager who had a DoLS in place and who had they applied for a DoLS for and they were unable to tell us. They said that the deputy manager had dealt with these and was not present at the inspection. The registered manager was not aware of the details of any DoLS authorisations including any recommendations. Staff knew some people had DoLS in place but could not tell us who and if there were any conditions in the authorisation. The registered manager gave us this information after the inspection.

Staff had a mixed understanding of the Mental Capacity Act. Although staff were able to tell us the principles of the MCA, decisions had been made on people's behalf without assessing if they had capacity or involving their loved ones to make the decision. One person's needs had recently changed; their care plan stated they did not have capacity to choose their meals anymore. However, the person's daily notes showed they were regularly choosing from a choice of meals offered to them. There was a risk that staff would make choices for this person which they were able to make for themselves.

Each person had a capacity assessment in their file relating to 'consent to their care plan.' Capacity to make Individual decisions had not been assessed and there was no evidence of any best interest meetings when decisions had been made on people's behalf. For example, some people who did not have capacity had received an annual flu vaccination; there was no record of who had made the decision for the person to have the vaccination or the reasons why.

Some people were not fully involved in choosing what they wanted to eat each day. People were offered a choice between cheese salad and steak and kidney pie for lunch on the day of the inspection. Staff asked people which they option they would prefer. Some people required assistance to communicate and we asked staff how those people chose what they wanted to eat. One member of staff told us, "A couple may not understand, so we go for the main option, but take into account their likes and dislikes." Staff had not offered people additional support for example, by showing people pictures of the meals on offer or letting them choose between meals that had been cooked.

Food choices were discussed at residents meetings, however, in most of these meeting minutes it was documented, "Everyone happy with current tea and lunch menu." People had not been asked individually about what kind of food they would like to eat and people who needed more support with their communication had not been supported to have a say about the menu because communication aids were

not used.
The provider and registered manager had failed to enable and support people to communicate their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On Shrove Tuesday staff had recorded that people had been offered a choice of different toppings for their pancakes such as lemon and sugar and fruit for their pancakes. We asked people about pancakes and their chosen toppings. They smiled and nodded, indicating they had enjoyed the day.

Some people had eating and drinking guidelines in place from a speech and language therapist. Staff followed these guidelines and food and drinks were served at the correct consistency. People received the support and supervision they needed to eat safely, during meals. However, there was no guidance for staff about how to respond if people were to choke. Food and fluid charts and weight charts had been completed to monitor people who were at risk of malnutrition.

People had health care passports in place, which showed the support they would need if they attended hospital. People's health needs were recorded in their care plans, with some information about how they preferred to be supported. People needed support to attend health appointments and to understand any information given by health professionals so staff supported people to attend and discussed any outcomes with them. Staff made records of any consultations or decisions made. However, this information was not always shown in the person's care plan or shared with the staff team so there was a risk that people would not get the support they needed to stay healthy.

Referrals were made to health professionals by staff when needed. Staff contacted health professionals quickly if there was deterioration in people's mental or physical health. Staff worked with the community teams to monitor people and keep people safe. When people attended day activities, staff communicated with the staff there, if appropriate to do so, about the person's health needs.

Inadequate

Is the service caring?

Our findings

People told us the staff were 'nice' and that they liked them. Staff told us, "We all get on really well both with staff and the people we support. We've built really good relationships here." However, we found that staff were not always caring in their interactions with people.

There were times, during the day, when staff did not interact with some people, for long periods of time. For example, for at least one hour during the morning staff did not approach or interact with several people who had more complex needs, staff walked past people but did not speak to them or give them eye contact. Some people appeared withdrawn and staff did not interact or engage with them for example, one person was listening to their music, they occasionally looked at staff as they walked past, the staff did not smile or speak to them. When people approached staff, if they were able, they responded and chatted to them.

Communication was not supported. Information was not always provided to people in an accessible way that was meaningful to them and the environment did not support communication. For example, there were no pictures of the activities which would be happening and staff did not look for ways for people to communicate. The registered manager and staff told us that some people "Did not communicate at all." Some people did require additional support with communication, however when we sat with them they smiled and reached out and touched our hand, which is a form of communication.

Some people had a DISDAT (Disability distress assessment tool) in place; this is a document which records how people communicate if they are unhappy or unwell through their behaviour or facial expressions. However, this information had not been added to people's care plans or risk assessments, so staff were unaware of it and of the signs to look for when supporting people. Staff told us, "You have to get to know people; I know that sometimes challenging behaviour is a way for people to tell you things. You have to try and work out what."

There was no information displayed about what people could choose to eat that day. There was a board in the lounge that had some pictures of activities displayed, however these did not match what was happening at the service that week. Staff told us they did not use the board as it was, "Not effective" but no consideration had been given to alternative means of showing people what was on offer each day.

People were not all encouraged to be as independent as possible. Some people were able to be more independent and do more for themselves but others, with more profound needs, were not supported to develop and increase their independent skills. We observed staff doing things for people instead of with them. For example one member of staff told a person, "I am going to make your bed and then I will be back down" and did not involve the person in this activity. Some people sat for long periods of time in the lounge with little interaction from staff. There were no plans to support people to learn new skills like cooking or budgeting money.

The language used to describe people was not always respectful. In one person's daily notes staff had written, '[The person] was rude to staff and tried demanding to get up at 5:45. It was explained it was too

early and they got up at 6am.' We discussed this with the registered manager and they agreed that people should be able to get up whenever they wished.

There was a risk assessment in one person's file that was titled, 'social graces.' This related to the person's behaviour at meal times and although it detailed how to ease the person's anxiety when they were about to eat the focus was on ensuring they adhered to 'social norms' when eating as opposed to how to support them fully and individually.

Staff regularly described people's behaviour as either, 'acceptable' or 'unacceptable.' There was no consideration as to what people may be communicating by their behaviours.

People were not involved in the running of the service. People were asked for their views in meetings, but people who required additional support or tools to communicate were not given the support needed to be involved so were no included.

There was an open plan kitchen that was part of the dining room and lounge so the kitchen was accessible to everyone. However, there was a sign in the kitchen that stated, 'Under no circumstances are non-members of staff permitted to use any kitchen appliances.' Staff told us that this sign was directed at relatives; however they also confirmed that people were not supported to use the kitchen at any point. One member of staff said, "We will set up squash for people and if they can they might pour it themselves I guess. [Person] and [person] can make their own drinks but we make it up to ensure it is the right consistency… people just don't use the kitchen, it is for their own safety." There were no plans in place to increase people's skills within the kitchen or involve them more in food preparation.

People did not always receive care and support in the way they preferred and were not enabled to understand their care and support options. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

One person told us, "I like going out, I am going in the car soon." Staff told us, "Most people like to go out but not everyone does. They really enjoy the music man who comes."

Some people regularly accessed local day centres and went out to the cinema or for walks with staff. However, people with higher support needs did not go out regularly or participate in meaningful activities. One person's care plan stated, '[The person] enjoys one to one time with staff and going out in the community.' Although it was documented that the person enjoyed going out they had only been out twice in March 2017, once to go out for lunch and once to take part in a gardening activity.

Another person's care plan stated they enjoyed going out in 'the community' and 'going out for coffee.' Between 27 February and 20 April 2017 this person had only left the service to attend three healthcare appointments and had not been out apart from that. We asked staff if the person went out regularly and one staff member told us, "Not very often. They do enjoy it when they are out. They can be quite challenging and require quite a lot of prompting though." The registered manager told us, "[The person] can be very challenging so some staff do not feel confident taking them out." Although they recognised that staff were not confident supporting some people when out, no staff at the service, including the registered manager had received any training in supporting people with their behaviour. There was no guidance in place for staff on how to support people safely if they became anxious or distressed when out in the community and no plans in place to increase staff confidence around this.

The registered manager showed us team meeting minutes from 16 December 2016. These stated, "If you feel certain clients aren't going out as much as others, speak up. Check with a senior if it is ok for you to take them out for coffee." Four months later, at our inspection, the situation had not improved and some people were still not going out regularly. The registered manager did not monitor when people were going out, even though it had been identified that some people were not going out as much as they should, there were no plans in place to offer people the opportunity to go out more often.

Staff did not always follow guidance provided by healthcare professionals. In one person's care plan we saw a speech and language therapy report dated 27 April 2016. The speech and language therapist had recommended staff 'implement visual day planning' with one person, 'to support them to understand what is happening and help them with any changes or transitions.' This was designed to ease the person's anxiety around going out and helped staff to plan with the person their activities for the day. We asked the registered manager if we could see the person's visual day plan and they told us they had, "Completely missed that." Staff were not assisting the person with visually planning their day. The person sat in the same chair, listening to music for most of the inspection without any interaction from staff.

One person's care plan stated they no longer spoke, however, their daily notes frequently said '[the person] has been very chatty today.' Updates had been added to the person's care plans but out of date information had not been removed. As a result, the information was confusing and there was a risk staff would not be following the most up to date guidance.

People were not involved in developing and updating their care plans. People's care plans were not always person centred and some contained inaccurate information. Some people did not have any personal goals recorded. One person's goal stated, 'To address all behaviour issues and find solutions to provide a happy home life.' However, there was no plan about how this was to be achieved. When people did have goals recorded there was no plan for how they would achieve the goals or how they would recognise they had completed the goal. In order for people to develop new skills or maintain skills they have developed, it is important for them to have a plan with steps towards a goal. This ensures staff offer people the correct support towards their goals and do not do things for people which they could do themselves. Without clear plans people may not achieve their goals and develop skills to lead fulfilling, meaningful lives.

People did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the afternoon of the inspection a performer visited the service, playing music and encouraging people to sing and dance. This was attended by people from all of the provider's services. People appeared to enjoy the activity, some people sung songs on the microphone and others joined in with a sing along. Then people and staff joined in dancing together. Lots of people were smiling and laughing.

People were given information about how to make a complaint. There was an easy to understand version of the complaints policy available. However, there was no system in place to support people with more complex and communication needs to make a complaint. No complaints had been received since April 2016.

People were asked in monthly meetings if they had any concerns and were given the opportunity to speak to the registered manager or deputy manager on a one to one basis. People's views were also sought via regular surveys that were sent to them by the provider. Surveys were primarily a tick box with opportunities for people to comment if they wished. The responses on the surveys were positive and no suggestions had been made by people about how the service could be improved. There was no system to support people with more complex needs to give feedback. People could access advocacy services if they wished although no one at the service currently had an advocate. An advocate is someone who supports a person to make sure their views are heard and rights upheld.

Inadequate

Is the service well-led?

Our findings

People told us they liked the registered manager, one person said, "They are great." Staff told us the registered manager was very approachable and supportive.

The culture of the service, was one that staff 'did for' people rather than 'with them.' There was opportunity to increase people's control of their lives by supporting them to do more for themselves and by supporting people to be more involved but this was not happening. Throughout the inspection staff predominately spent time with people who approached them and had less complex needs. Staff did not look for ways to support people to make choices or communicate. Staff stated that some people were 'unable to do these things' without trying to involve people in some way. Neither the provider nor the registered manager had recognised this poor culture.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action has been taken. The registered manager had not submitted notifications relating to people's DoLS being authorised, as required by law, in a timely manner. Incidents of possible abuse had not been reported appropriately.

The provider and registered manager had failed to notify CQC of notifiable events in a timely manner. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was currently completing a qualification relating to the management of health and social care services. They had worked at the service for a number of years, progressing from a support worker role to registered manager. The registered manager did not have a plan to develop and maintain their skills or keep up to date with good practice. They did not have a clear understanding of person centred planning or positive behaviour support which is best practice when supporting people with a learning disability. The registered manager did not currently attend local forums for registered managers or providers where they could hear about examples of good practice and share experiences. The registered manager said they would like to attend forums in the future and complete some additional training about person centred planning. They agreed this would be beneficial to them and the service.

Audits were carried out by the deputy manager and registered manager. The results of these and any actions taken or needed were included in a monthly report sent to the providers. If any issues were uncovered they were addressed and fed back to the staff. The registered manager spent time at the service and observed staff interacting with people, but had failed to identify the issues with some people not receiving the support they needed. The provider did not complete any audits of the service themselves and relied on the registered manager's reports to assess the quality of care being delivered.

Audits covered medication records and financial records. The use of 'as and when required' medicines had not been reviewed as part of the auditing process and the registered manager was unaware of the issues found during this inspection. People's care plans and risk assessments were not audited, which meant the registered manager could not be sure they showed people's full range of needs, were up to date and gave

staff the guidance they needed. Some guidance given by health and social care professionals had been overlooked and not incorporated into people's care plans or support. People were not involved in developing and updating their care plans. People's care plans were not always person centred and some contained inaccurate information. Other audits of the service had not highlighted the issues found at this inspection.

Some accidents and incidents were reviewed and any learning from them was shared with the staff team and the provider. Changes were made to risk assessments, care plans and referrals to professionals were made or advice was sought if needed. However, the registered manager did not review all incident forms which resulted in possible abusive incidents not being recognised or reported in line with the provider's policy. The registered manager told us they would ensure they reviewed all future incident reports before they were filed. People's behavioural incidents were not reviewed or analysed to look for any common themes or triggers, this could result in people getting inconsistent support with their behaviours.

People were asked for their feedback through house meetings and surveys. Surveys were primarily a tick box with opportunities for people to comment if they wished. The responses on the surveys were positive and no suggestions had been made by people about how the service could be improved. There were no systems in place to seek feedback from people with more complex needs so staff had completed surveys on people's behalf.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to respect and involve service users and had failed to maintain accurate and complete records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager requested feedback from other people involved with the service such as health and social care professionals, relatives and staff. These were generally positive with comments such as, "The staff are very kind and caring." and "There is a lovely atmosphere, the staff clearly know their role."

Outcomes of surveys along with other news about the provider's services was shared with people and relatives through a quarterly newsletter. It also let people know about changes in staffing or upcoming events.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had failed to notify CQC of notifiable events in a timely manner.

The enforcement action we took:

Positive condition imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to enable and support people to communicate their preferences. People did not always receive care and support in the way they preferred and were not enabled to understand their care and support options. People did not always receive person-centred care.

The enforcement action we took:

Positive condition imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to people's care and support were not always adequately assessed or mitigated. Medicines were not managed safely. The provider had not ensured that staff had all the training they required to meet people's needs, support them consistently and keep them safe.

The enforcement action we took:

Warning notice issued to registered manager and provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment Staff and the registered manager were not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. People were not fully protected from abuse and the registered manager had not followed the correct procedures to make sure people were as safe as possible.

The enforcement action we took:

Positive condition imposed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to respect and involve service users and had failed to maintain accurate and complete records.

The enforcement action we took:

Positive condition imposed