Georgian House (Torquay) Limited

Georgian Annexe

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25, 26 and 28 July and 2 August 2017. The first day of the inspection was unannounced. This was the first inspection of Georgian Annexe since it registered with the Care Quality Commission (CQC) in August 2016. Georgian Annexe is a purpose built residential home, which can support up to 14 people. All bedrooms are en-suite and one room is self-contained with kitchen facilities. Lifts provide access to all floors.

The inspection was prompted in part by information received from Torbay and South Devon NHS Foundation Trust about three safeguarding concerns in relation to people living at this service. These related to punitive and restrictive practices within the home and people not receiving safe care and support. These incidents are subject to further investigations by other authorities and as a result this inspection did not examine the all of the circumstances of these incidents.

However, the information shared with CQC about the incidents indicated potential concerns about unsafe and improper treatment of the people living at Georgian Annexe. This inspection examined those risks.

Georgian Annexe is registered to provide personal care and accommodation for up to 14 adults who require support with their mental and physical health. At the time of the inspection, 12 people, one of whom was a younger person under the age of 17years, lived at the service. The service's registration with CQC did not support the admission of people under the age of 17years. Following the inspection, this young person was moved to alternative care provision.

The service had a registered manager in post who was also registered to manage another of the provider's services. 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. Following the inspection, the registered manager submitted an application to CQC to cancel their registration.

The provider and registered manager failed to ensure the systems and processes in place were effective in ensuring the service is compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During the inspection we identified a number of breaches of the regulations including those relating to a safe environment, protecting service users from harm and improper treatment, mitigating risks to service users health and safety, insufficient staffing levels and the quality of information and guidance contained within service users' care and support plans.
Lack of supervision and oversight of staff practices within the home failed to identify the restrictive and punishing practices used by staff to manage people's behaviour. The service did not have effective systems in place to assess and plan for people's care needs or to monitor staff competence and skills to carry out the

tasks required of them. The provider and registered manager failed to notify the CQC of significant incidents affecting people's health, safety and well-being.

Immediately following the inspection, as a result of the interim outcome of the safeguarding process, the provider appointed a Care Consultancy Service to support the management team. We also asked the registered manager and provider for an urgent action plan to be put into place to mitigate the immediate and serious concerns we had identified. This was received on 3 August 2017. On 4 August 2017, we imposed conditions on Georgian Annexe (Torquay) Ltd registration. These included preventing Georgian Annexe from taking any new admissions, to ensure staffing levels were as contracted, to ensure the service met fire safety regulations and to report weekly to CQC the actions taken by the provider and the Care Consultancy Service to ensure people's safety. CQC will review these weekly reports to identify if risks to people's health, safety and welfare are being appropriately managed.

People living at Georgian Annexe were not receiving safe care and support. We identified a number of significant concerns in the way people were being supported. These included how staff supported people to manage risks associated with their behaviour; staffing levels in the service both during the day and overnight; the safety of the environment with regard to fire precautions and how medicines were being managed. During the inspection we made safeguarding referrals for three people to Torbay and South Devon NHS Foundation Trust (the Trust). We attended two safeguarding meetings on 26 and 31 July 2017 to review the safety and wellbeing of the people living at the service. Following the first meeting, the service was placed into 'whole service' safeguarding by the Trust which meant they had concerns about people living at Georgian Annexe. As a result health and social care professionals commenced urgent reviews of each person's care and support needs and whether these were being met at Georgian Annexe.

Many of the people living at Georgian Annexe had needs in relation to their mental health conditions, including obsessive and compulsive behaviour, depression and suicidal thoughts and behaviour which placed themselves and others at risk of harm. Assessments to identify these risks were either insufficiently detailed to guide staff about how to support people to mitigate risks, or where detailed information was provided, this was not being followed by staff.

People were not protected from the use of punitive, threatening and improper treatment. The service was using a document called responsive support plans to guide staff with the support of people's behaviour. These plans had been written by a member of staff who had no specialist knowledge people with complex mental health needs. Staff referred to these plans as 'traffic lights' as they described people's behavior in terms of "green", "amber" and "red". The plans were excessively restrictive and did not provide clear rationale for staff about how they should respond to service users' behaviours. For example, people would have their furniture removed from their rooms or face other restrictions such as having to remain in their rooms. Staff used this system to threaten people with the consequences of moving into the 'red' area of their responsive support plan.

People rights under the Mental Capacity Act 2005 were not respected. People's consent to receive care and support had not been recorded and people's capacity to make decisions about their care and treatment were not properly assessed. Some people were potentially having their liberty unlawfully restricted with the use of locked external doors and no way to exit with building without staff agreement. The service used closed circuit television (CCTV) in the majority of communal areas around the building. People's consent to the use of this had not been recorded and some people's privacy was breached as the cameras gave a view directly into their bedrooms.

Staff used disrespectful and de-personalised language when talking about people's wellbeing. Rather than

refer to how people were feeling or how they were managing their anxieties and behaviours, staff referred to them as a colour on their traffic light system. We heard staff refer to people as being on 'red' or on 'green'. Staff also used unprofessional terms in people's care records. Staff described people as being in a good or bad "headspace" in their daily care notes without describing what this meant for the person. Without this description people's care and support plans cannot be reviewed and amended to be more personalised and reflective of their needs.

Insufficient numbers of staff were employed at the service to ensure people received safe care and support and to meet the contractual staffing arrangement made by the commissioning authorities. Staff told us they did not have the training or skills to support people with complex mental health needs. One member of staff told us, "People are not safe and neither are the staff. There aren't enough staff and we are not trained." With the exception of one day's training in challenging behaviour and breakaway techniques and another in physical intervention, staff had received no training specific to the needs of those people living at Georgian Annexe. Staff were not provided with supervision or support in their role. Although staff told us they were able to speak to members of the management team, there was no evidence staff were provided with formal supervision or appraisal of their work performance or training and development needs.

People could not be assured they would receive their medicines as prescribed. One person had not received a prescribed medicine to help manage their mental health condition for five days and another person did not receive the correct dose of a prescribed medicine on four occasions. Although neither person suffered undue consequences, this demonstrated staff were not managing people's medicines safely.

Care plans and responsive support plans (traffic light system) failed to provide staff with information and guidance about how to promote people's positive behaviour as part of an approach in reducing people's self-harm or aggressive behaviour. There was a lack of strategy to teach and support people to develop skills so they could develop less harmful ways of communicating their needs.

People told us they did not always receive the care and attention they needed from staff to promote their independence. Where people had identified personal goals to achieve while living at Georgian Annexe, there was no evidence people received support to achieve these goals. Care plans provided no information for staff about how to support their independence. People at risk of social isolation were not being supported to become involved in any meaningful engagement.
Some people had needs in relation to healthy eating: some people were overweight while another person had past history of an eating disorder. People's care plans did not provide sufficient guidance for staff about how to support people with their eating or what actions to take should staff have concerns over their eating and drinking.

The service did not respond to or record complaints well. A centralised record of complaints was not kept and it was not possible without reviewing each person's computerised records whether they had raised any concerns. Where concerns had been raised these were not effectively managed to support people making the complaint.

Staff were recruited safely and all seven files we looked at contained evidence of pre-employment checks being undertaken. These included disclosure and barring checks (police checks) and references from previous employers. Records showed staff received some training in health and safety topics, such as safe moving and handling as well as safeguarding adults but they had not received training in safeguarding children. This training was necessary for the service to be able to admit young people under the age of 18years. The registered manager told us the safeguarding training included both children and adults; however the certificates did not indicate this. Although staff told us they were aware of their responsibility to

keep people safe, they failed to identify some of the practices within the home were abusive and breached people's rights to receive safe, respectful and dignified care

The environment was not always managed safely. Changes made to the fire door of one person's bedroom placed them and others at risk in the event of a fire. The service had not sought advice from the fire authority before making these changes. During the inspection, we contacted the fire authority to alert them of our concerns and they provided advice to the service about fire safety precautions for people at risk of self-harm.

People expressed mixed views about the kindness of the staff towards them. Some staff were praised, with people saying particular staff were "nice" and "talk to you" while others were described as not caring. During our inspection we observed staff in kind and thoughtful interactions with people, comforting people who were upset and in conversation with people about their interests. However, we also saw staff ignoring people when they had an opportunity to participate together in activities that would promote people's well-being.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from risks to their health, safety and wellbeing. People were exposed to abusive practices and physical aggression from others.

Staff were provided with insufficient information about people's care to enable them to support people safely. Where controlled measures were in place these were not always adhered to.

Insufficient numbers of staff were employed at the service to ensure people were safe.

People could not be assured they would receive their medicines as prescribed.

Changes to the fire safety precautions placed people at risk in the event of a fire.

Is the service effective?

Inadequate

The service was not effective.

People were subjected to punitive and improper treatment with the use of restrictive practices designed to support people in managing their behaviour.

People's rights under the Mental Capacity Act 2005 were not protected. Some people's liberty was potentially being unlawfully restricted.

Staff did not receive the training they needed to support people with complex mental health needs. Staff had little understanding about how to respond to people's anxieties and behaviours.

Staff were not appropriately supported or supervised to ensure their work practices were safe and supportive towards people's needs and goals.

People's nutritional needs were not being properly assessed or monitored.

Is the service caring?

Inadequate

The service was not caring.

People did not always receive support from kind and compassionate staff.

People were not supported to maintain their independence.

People were not involved in planning or agreeing to their care plans.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive support responsive to their needs. Care and support plans did not provide sufficient guidance for staff about how to meet people's support needs.

People's social care needs were not always met.

Complaints were not properly recorded, investigated or actioned.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by a management team who had experience and qualifications in supporting people with complex mental health conditions.

There were no effective systems or processes in place to ensure that the service was safe, effective, caring, responsive or well led. The provider and registered manager failed to protect people from punitive and unsafe care.

The provider and registered manager failed to notify CQC of significant incidents in the home.

Georgian Annexe

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 checked whether the provider was 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 25, 26 and 28 July and 2 August 2017: the first day was unannounced. Two adult social care inspectors undertook the inspection on the first three days, and one adult social care inspector completed the inspection on the fourth day. Prior to the inspection we received information from Torbay and South Devon NHS Foundation Trust about three safeguarding concerns in relation to people living at this service. These related to punitive and restrictive practices within the home and people not receiving safe care and support.

Before our inspection, we reviewed other information we held about the home. This included correspondence we had received and notifications submitted by the service. A notification must be sent to CQC every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. 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. The PIR was completed and returned in June 2017.

During the inspection we met seven people and spoke with four people in detail about their care. Some people said they did not wish to speak to us. Some people made very negative comments about the service which we have not included in this report but passed to the relevant health and social care professionals. We spoke with the provider and registered manager and ten care staff including members of the management team. We looked at seven people's care records, seven staff recruitment files, records relating to staff training and supervision, medication administration records and other records relating to the management of the service. We reviewed some CCTV footage, however we were informed that CCTV footage was not available prior to 29 July 2017 as following an upgrade to the service, the footage had been mistakenly erased. We observed people and staff throughout the inspection and saw how people were being supported.

During the course of the inspection we attended two safeguarding meetings held by Torbay and South Devon NHS Foundation Trust and spoke with health and social care professional involved in the care of all those living at Georgian Annexe. As a result of our inspection findings we made three safeguarding referrals to the Trust.

Inadequate

Is the service safe?

Our findings

People living at Georgian Annexe were not receiving safe care and support. We identified a number of significant concerns in the way people were being supported. These included how staff supported people to manage risks associated with their behaviour; staffing levels in the service both during the day and overnight; the safety of the environment with regard to fire precautions and how medicines were being managed. During the inspection we made safeguarding referrals for three people to Torbay and South Devon NHS Foundation Trust (the Trust).

We attended two safeguarding meetings on 26 and 31 July 2017 to review the safety and wellbeing of the people living at the service. Following the first meeting, the service was placed into 'whole home' safeguarding by the Trust which meant they had concerns about the people living at Georgian Annexe. As a result health and social care professionals commenced urgent reviews of each person's care and support needs and whether these were being met at Georgian Annexe.

Many of the people living at Georgian Annexe had needs in relation to their mental health conditions, including obsessive and compulsive behaviour, depression and suicidal thoughts and behaviour which placed themselves and others at risk of harm. Assessments to identify these risks were either insufficiently detailed to guide staff about how to support people to mitigate risks, or where detailed information was provided, this was not being followed by staff. For example, one person had needs in relation to self-harm. Their care plan described them as having "undertaken several serious acts of self-harm and suicide attempts". The actions and guidance for staff identified in the care plan stated, "Work with [person's name] for ways to cope with stress rather than self-harm." There was no further guidance for staff about how to support this person when they became anxious or harmed themselves, or what action to take should they express suicidal thoughts. The measures in place to mitigate risks to this person's health and safety were poorly described in their risk assessment. The agreed actions included talking to the person, removing any sharp objects and flammable liquids. It also stated the person was to be put under observation and emergency services to be contacted. However, the risk assessment did not guide staff about what level of observation the person should be placed under and when the emergency services should be contacted.

Records showed this person had self-harmed on two occasions in July 2017. On one of these occasions this person required hospital treatment. On the first day of the inspection, the registered provider told us this person was receiving one-to-one staff support at times both during the day and overnight.. During the inspection this person told us they were not receiving sufficient staff support and they made very negative comments about the service. They said they were not being supported to manage their anxieties which led to the incidents of self-harm. An incident form completed by staff on 17 July 2017 included a statement from this person saying, "If this is what needs to be done to get me out of this [the service] I'll do it, and again." We were unable to ascertain from looking at this person's daily care notes and the duty rota whether this person received any one-to-one support. The service did not keep records of which staff members had been allocated to support which person on a daily basis. We raised our concerns about this person's wellbeing with their social worker. They confirmed staff had made them aware the person had self-harmed and had asked for guidance in relation to risk management. However, they had not been made aware the person had

required hospital treatment nor that they had said they would continue to self-harm if they remained at the service.

Another person had risks associated with self-injurious behaviours and aggression towards others. This person's care plan described them as having "high anxiety levels" and demonstrating "extreme self-harming behaviours" and aggression to others. Records showed this person had frequent episodes where they harmed themselves, at times to such an extent that medical intervention was necessary, including surgery. The risks to this person were so significant, they required the support of two staff at all times. On 29 July 2017 this person was able to obtain a pair of scissors from the office and use these to harm themselves. CCTV footage showed that no staff were supporting this person before they obtained the scissors and that staff did not follow this person once they had seen that they had obtained the scissors. The incident form completed by staff stated, "She was cutting deep in to her wound and cut in to the subcutaneous fat." This demonstrated staff were not providing the support necessary to keep this person safe which had resulted in serious harm to them. We made a safeguarding referral about this person's safety to the Trust.

We asked the management team to show us how they reviewed the number and type of behavioural incidents to see if there was a trend of aggression and self-harm had come about, and whether any steps could be taken to mitigate these risks. They informed us incidents were regularly reported to the commissioning authorities, but there were no records showing that formal analysis took place.

One person had strict restrictions to their liberty to mitigate risks to their safety and that of others. These restrictions were well documented, however, records showed that despite clear guidelines why these restrictions were in place, staff had not always adhered to these. This had a significant impact upon their wellbeing, causing distress and increased anxiety as they were not receiving consistent support: this placed them and others at risk of harm.

People could not be assured they would receive their medicines as prescribed. For example, one person had not received a prescribed medicine to help manage their mental health condition for five days. There was no action identified in the handover information between the night and day shifts that the home had run out of this medicine. It was only as a result of the inspection that this omission was identified. We asked the service to inform the person's GP to ascertain whether this placed them at risk and to obtain more of the medicine. Another person did not receive the correct dose of a prescribed medicine. The prescribing instructions had been incorrectly written by staff on the person's medicine administration record (MAR). This had resulted in the person receiving double the dose of the medicine for four days. Although neither person suffered undue consequences as a result, this demonstrated staff were not managing people's medicines safely.

Some people had been prescribed medicine with a variable dose to take "as and when needed" (prn) with a variable dose. The information for staff was not clear about which dose should be administered. One person's prescription said to give 0.5mg or 1mg of the medicine, however there was no guidance for staff about whether to administer the lower dose first and assess its effectiveness in reducing the person's anxiety before administering more. Additional records were maintained for the prn medicines to show what dose and why the medicine had been administered. Two of these records were inaccurate and did not reflect the entries made on the MARs. For example, one person's prn records and MAR showed different doses of medicines given and another person's records indicated they had been given a medicine they had not been prescribed.

During the inspection one person raised concerns with us about changes made to the fire door and the windows in their bedroom. They asked us to look at their room as they felt the changes left them at risk should there be a fire. A member of staff showed us the person's room and explained that the intumescent

strip, door latch and door closure device had been removed from the door. This meant the door did not close and would not have slowed the spread of smoke into, or out of, the bedroom. Staff informed us these changes had been made as the person was at risk of using the intumescent strip as a ligature and the door closure and window handles as ligature points. The fire risk assessment for this person's bedroom did not contain any of this information and the risk had been rated as low. There was no evidence staff had consulted with the fire authority before making these changes. We consulted with the fire authority who informed us the changes made would not be considered safe and following the inspection they provided Georgian Annexe with guidance about how to ensure the environment remained safe for people who may be at risk of using ligatures to self-harm.

Failure to ensure people receive safe care and treatment and are protected from avoidable harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff received some training in health and safety topics, such as safe moving and handling as well as safeguarding adults but they had not received training in safeguarding children. This training was necessary for the service to be able to admit young people under the age of 18years. The registered manager told us the safeguarding training included both children and adults; however the certificates did not indicate this. Although staff told us they were aware of their responsibility to keep people safe, they failed to identify some of the practices within the home were abusive and breached people's rights to receive safe, respectful and dignified care. When asked to explain why it was necessary for some people to have their belongings and furniture removed from their rooms, some staff weren't able to say and did not appear to recognise this was a punitive response to supporting people to manage their behaviour. Some people told us they did not feel safe at the home and records showed there had been incidents when people had been physically assaulted by other people living at Georgian Annexe.

Failure to protect people from abusive and improper treatment a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported in a safe way as there were insufficient numbers of staff employed at the service. At the time of the inspection 12 people were living at Georgian Annexe. The registered manager and management team told us there were enough staff on duty to meet people's care and support needs. To enable us to assess whether there were sufficient staff on duty, we were provided with this information from the Trust. Seven people required the support of either one or two members of staff, either at all times or overnight. The duty rotas for the period 10 to 30 July 2017 indicated there were between eight and nine staff on duty during the day and six staff overnight. With seven people requiring 10 staff between them during the day and at least nine staff overnight, these numbers were insufficient to ensure people received safe care and support at Georgian Annexe. One member of staff told us, "People are not safe and neither are the staff. There aren't enough staff and we are not trained." Other staff told us that at times of staff sickness there were not enough staff on duty.

Failure to provide sufficient numbers of staff to meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Only staff who had received training in the safe administration of medicines and had been assessed as competent by a senior member of staff supported people with their medicines. Records showed staff had received training and been assessed on three separate occasions before they were permitted to administer medicines unsupervised. A senior member of staff undertook regular audits of the medicine records to ensure these had been completed appropriately and we saw evidence of these audits. With the exception of

the person who had not received their medicine for five days, we saw the MAR records had been fully completed.

Records showed staff were recruited safely and all seven files we looked contained evidence of pre-employment checks being undertaken. These included disclosure and barring checks (police checks) and references from previous employers.

Inadequate

Is the service effective?

Our findings

People were not protected from the use of punitive, threatening, degrading and improper treatment. The service was using a document called responsive support plans or "traffic lights" to guide staff with the support of six people's behaviour. We were told by the provider and registered manager that the responsive support plans were to guide staff in responding to people in a way that promoted their positive behaviour and should not be used in a threatening or punitive way. In the service's policy on "the use of the traffic light system", the provider identified the system was, "a tool to manage risk and to support staff and client in a non-punitive approach to maintain their safety." The policy also stated, "The least restrictive option should always be used and any action taken needs to be for the shortest time possible…"

We found the plans to be excessively restrictive and they failed to provide a clear rationale for staff about how they should respond to service users' behaviours. Staff were using the plans in a threatening and degrading way towards people and as a punitive measure to manage people's behaviour. During the inspection we heard staff describing people in terms of "green", "amber" and "red" depending on where their behaviour placed them on the traffic light system. On the first day of the inspection, 25 July 2017 we saw one person's room. All furniture with the exception of a mattress on the floor, a wardrobe fixed to the wall and a box of cushions had been removed. We were informed the person was 'on red', as indicated in their responsive support plan, resulting in their possessions being removed from their room. When we asked staff why the person needed to have their possessions removed, one member of staff said, "I couldn't say" and another said, "I don't really know". We were told by a senior member of staff that removing the furniture and other possessions was to ensure the person's safety, and was not a punitive measure. This person's responsive support plan stated that items which the person could use to harm themselves or others should be removed from their room. However, their care plan provided no information about how to support this person in managing their behaviours. There was no reference to how to promote this person's positive behaviour and minimise their negative, self-injurious and aggressive behaviours.

This person's daily observation records for the previous day, overnight and the morning of the inspection gave no information about why it was necessary to remove this person's furniture. This indicated the removal of the person's belongings and furniture was not undertaken in the least restrictive way or for the shortest period of time when the person was no longer posing a risk to themselves or others.

Records for another person provided further evidence staff were using the traffic light system as punishment for people. On 10 July 2017 this person was "on red" and had spent the day in their room "irrelevant to whether or not he went on to green." On 24 July 2017, this person was threatened with the consequences of moving into the 'red' area of their traffic light system. Their daily care notes stated, "Just the threat to get on red was stopping him getting worse." Following the inspection the Trust provided us with a copy of a behavioural incident form dated 14 August 2017 showing that staff were continuing to use threats of punishment to manage this person's behaviour. In the report a member of staff recorded "[name] was told that his night out on Wednesday (16 August) was going to be cancelled".

The service's policy also stated the traffic light system, "is also a tool to look at future goals and ways to progress these in a safe manner." However, the plans failed to identify people's positive behaviours and how these should be promoted and supported. Records did not show how the provider or registered manager reviewed this system's use and whether it was being used in line with national guidance and good practice. The use of the plans demonstrated a practice of punitive and temporary solutions for long term issues that did not address, and possibly worsened, the underlying causes for the behaviour. There was a lack of strategy to teach and support people to develop skills so they could develop less harmful ways of communicating their needs.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the provider and registered manager had failed to ensure the service was adhering to the Deprivation of Liberty Safeguards Code of Practice.

Georgian Annexe had electronic locks on all internal and external doors. All doors were unlocked with the use of a key fob programmed specifically for each person to allow them access to their own room and the communal lounge rooms. Some of the external doors were open during the day and people were free to come and go to the secure patio areas. The registered manager told us that where people had been assessed as safe to leave the home without supervision, their key fobs gave them access to unlock the front door. We asked them to show us how the key fobs had been programmed for each person. The computer records showed that no-one's key fob gave them access to the front door. This meant that people were unable to leave the building without a member of staff opening the door for them. For three people this restriction had been authorised by the local authority to ensure their safety as they would be at risk should they leave the service without supervision. For a further three people, applications had been made to the supervisory body for authorisation. However, for the other six people living at the service, this restriction was a breach of their rights and was potentially an unlawful restriction.

Failure to protect people from abusive practices and improper treatment, and restricting people's liberty without proper authorisation is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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. Some people had the capacity to consent to receive care and support assessed by the local authority. Where this had been done, people's abilities and support needs were described well. However, where the service had undertaken capacity assessments these did not always identify the specific decision under review or how people had been supported to make decisions about their care and support. For example, one person's capacity assessment identified the need to support them with managing their finances; however the assessment discussed the person's care and support needs, a restriction to their liberty and the use of alcohol. There was no description about how the person was supported to make decisions, other than a statement that said, "(name) does not have capacity with complex decisions" and no best interest decision was recorded.

In another assessment, in answer to the question, "Can they understand the decision?" the registered manager had recorded, "Can be distracted and returned to later to help the task be achieved." This demonstrated the provider and registered manager did not have the knowledge and skills to support people to make decisions about their care, or to properly assess their capacity.

Records showed staff had not received training in the MCA, although some of the staff we spoke with did understand people's rights to make choices and decisions. Records did not identify whether people had contributed to developing their care plans. Since the inspection the owner of this service has said that some, not all, staff had received MCA training.

The service used CCTV in the majority of communal areas around the building. The use of this was identified in the Service User Guide provided to people prior to or at the time of their admission. Records did not identify the use of CCTV had been discussed with people and their consent sought for its use.

Failure to gain consent from people for the use of CCTV is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have the training or skills to support people with complex mental health needs. In the provider's Statement of Purpose, a document used to describe the service the provider stated, "All care is undertaken by our team of trained staff, who have a wealth of knowledge." However, records showed that with the exception of one day's training in challenging behaviour and breakaway techniques and another in physical intervention, staff had received no training specific to the needs of those people living at Georgian Annexe. After the inspection, the owner of Georgian Annexe told us some staff had received autism awareness training.

In a pre-admission assessment for one person with complex support needs, the provider said, "Georgian Annexe will provide effective learning disability and autistic focused positive behavioural support and nurturing." Another person's care plan identified they had autism which "impacts on her, and [name] thoughts are very black and white." There was no further explanation about how a diagnosis of autism affected this person. Staff had not received training in autism or positive behavioural approaches prior to or following these people's admission.

Staff told us they were able to speak to members of the management team should they require guidance and support. Although records were available that staff had received periodic formal supervision, these records did not specifically refer to staff competence and skills to carry out their role.

In the minutes of a meeting with a member of the management team on 11 April 2017, in relation to a discussion about one person's support needs, staff "voiced their fears and concerns and there was a consensus that sometimes they felt as though they were not sure how to proceed." Staff were provided with no guidance other than to refresh themselves with the current care plans.

Failure to provide staff with the support and training necessary for them to undertake their role is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always being met. Some people had needs in relation to healthy eating: some people were overweight while another person had past history of an eating disorder. Although advice was given to staff in May 2017 relating to healthy living, people's care plans did not provide sufficient guidance for staff about how to support people with their eating. For example, one person's body mass index was recorded in their daily care notes as "37.38 DANGER LEVEL". Their care plan stated staff were to

promote healthy choices of low fat foods and more exercise. However there was no further guidance for staff about seeking advice from a dietician, following a calorie controlled diet or what exercise the person enjoys participating in. There was no reference in the care plan about how often this person should be weighed or what action to take should they continue to gain weight. The daily care notes made no reference to this person undertaking any exercise.

Another person's care plan referred to their past history of an eating disorder, however staff were not guided about what action to take should this person indicate they were struggling with maintaining a healthy diet or showed signs of weight loss. The care plan guided staff to "support to have a healthy diet and normal fluids" with no further guidance about how to monitor this person's food intake or their weight. This person had identified having a healthy diet and starting to eat well as a goal they wished to achieve while living at Georgian Annexe. Their support needs were identified as help from staff to buy, cook and eat at least two healthy meals a day. However there was no further information about how this person was to be supported to achieve these goals.

Failure to ensure people's dietary needs were assessed and monitored is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people enjoyed the meals provided, others said they did not and they had no choice. Records maintained by kitchen staff showed that people were offered a choice from a variety of meals at lunchtime and in the evening. We saw people were able to take their meals in the dining room or their bedrooms. Where able people were supported to make drinks and snacks in the small dining and kitchenette area, and we saw some people being supported to do this during the inspection. For example, staff told us one person made themselves poached eggs every morning for breakfast.

Records showed that people had been referred to their GP if necessary and one person's care was overseen by the community nursing team. Staff supported people to attend hospital appointments or meet with health and social care professionals.

Inadequate

Is the service caring?

Our findings

People were at risk of and at times had been subjected to emotional, physical or psychological abuse. There were inconsistencies within the staff team about how people were being supported. For example, some people were not being provided with the staff support they needed to maintain their safety and that of others or to promote their independence. Records showed people had been subjected to verbal abuse and physical assaults by other people living at the service. People were threatened by staff with the consequences of moving into the 'red' area of their 'traffic light' system. There were inconsistencies with how staff implemented the strict guidelines in place to support one person with managing their behaviour. This caused this person confusion and distress.

Staff used disrespectful and de-personalised language when talking about people's wellbeing. Rather than refer to how people were feeling or how they were managing their anxieties and behaviours, staff referred to them as a colour on their traffic light system. Staff had little understanding of the impact this approach had on people's wellbeing and needs. Staff also used unprofessional terms in people's care records. Staff described people as being in a good or bad "headspace" in their daily care notes without describing what this meant for the person. When we asked the management team about this they said these terms were used by people and staff were reflecting this. Writing good or bad headspace failed to provide a clear description of people's wellbeing and the circumstances that had led to them being in this state of mind. Without this description people's care and support plans cannot be reviewed and amended to be more personalised and reflective of their needs.

The use of the CCTV breached people's rights of privacy: people had not consented to its use and one camera gave a view into a person's bedroom and their bed could clearly be seen.

The Service User Guide describes the service as one that provides "expert specialist care and support….enabling them [people] to be as independent as possible." In the Provider Information Return, the registered manager stated the service, "Inspire clients to look forward and improve". The provider gave us examples of when people had been supported with their development and promoting their well-being. One person had received dedicated staff support to return to education. Another person was supported to receive essential healthcare treatment. However other people did not receive this level of support. People told us they did not always receive the care and attention they needed from staff to keep them safe, promote their independence and ensure they had a good quality of life. For example, one person's care plan identified personal goals such as learning how to budget, to spend time gardening, to learn bus routes and to spend more time out. Their care plan provided no information for staff about how this person wished to be supported with these goals and there was no reference in their daily care notes with regard to this. They told us they did not receive any staff support with these goals and despite receiving one to one support they went shopping by themselves.

Another person's care plan stated, "[Name] will require prompting and assistance with essential tasks of daily living as required always promoting and encouraging her independence. [Name] is keen to be as independent as possible and is keen to prove it." It went on to say "[name] has a daily schedule and this

needs reinforcing on a daily basis with repeating and firm communication." Their care plan provided no information for staff about how to support their independence. In addition, staff often used the pre-populated responses when completing the computerised daily care notes and these gave a poor description of how this person had spent their day and how independence was being promoted. For example, 2 July 2017 their daily care notes stated, "[name] ate well at lunch", "[name] had chosen drink with lunch" and "[name] was chatty at lunch". These statements were repeated for later in the day when describing the person at suppertime, and were repeated throughout their care records for July 2017. Other than prompting with personal care and a reference to making their own cups of tea, there was no indication this person was receiving any support to promote their independence and there was no reference made to their daily schedule of activities.

People expressed mixed views about the kindness of the staff towards them. Some staff were praised, with people saying particular staff were "nice" and "talk to you" while others were described as not caring. During our inspection we observed staff in kind and thoughtful interactions with people, comforting people who were upset and in conversation with people about their interests. However we also saw staff ignoring people when they had an opportunity to participate together in activities that would promote people's well-being. For example, one person was singing and dancing in their room. This person had recently had their possessions and furniture returned to them after an incident that resulted in them being placed in the 'red' area of their traffic light system. This person was happy and smiling, however both the staff members supporting this person sat and watched them without any encouragement or attempt to join in this enjoyable experience.

Failure to treat people with dignity and respect, to protect their privacy and support their independence is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive care and support that was responsive to their needs. Care plans and responsive support plans (traffic light system) failed to provide staff with information and guidance about how to promote people's positive behaviour and independence.

There was no guidance for staff about how to support people's positive behaviour as part of an approach in reducing people's self-harm or aggressive behaviour. For example, when one person was in the 'green' area of their responsive support plan, staff were guided to "observe and reassure" and "listen actively and engage in positive emotional cues", rather than support the person to focus on their positive behaviour and attributes. When in the 'amber' area, staff were guided to "distract or de-escalate using talk down techniques" without guidance about how to do this and what de-escalation techniques had proved successful to the person in the past. Staff were also guided to "issue [name] with an amber flash card" and to explain the consequences of going into 'red'. This approach demonstrated the use of punitive and temporary solutions for long term issues that did not address the underlying causes for people's behaviour. There was a lack of strategy to teach and support people to develop skills so they could develop less harmful ways of communicating their needs.

The Service User Guide stated that people would be supported at Georgian Annexe to pursue a "fulfilled lifestyle of their choice, while being assisted to achieve goals and aspirations with dignity and respect." It went on to say that support workers were provided to "accompany individuals to partake in activities". The service employed an activity co-ordinator who told us they supported people to join in group and individual activities. However we found that some people with assessed needs in relation to social isolation were not being supported to become involved in any meaningful engagement.

In one young person's care plan under the section for daily life and social activities it described them as lacking motivation to get involved in activities and referred staff to support the person to go swimming as this was an activity they had enjoyed in the past. The actions guiding staff to support this person in social activities stated, "Discover what events or activities in particularly [name] enjoys and encourage [name] to engage in those." There were no activities, other than swimming, identified in the care plan. On the first day of the inspection the person showed us their craft work which was detailed and intricate: they were proud of what they had achieved. The person's daily observation notes referred to them being involved in colouring and craft work. However, their care plan did not refer to this and did not guide staff about how to support the person in these activities.

Another person's care plan described them as finding it "difficult to participate in generic activities and requires high levels of one to one to join in any activities at all during the daytime." It went on to say, "Make [name] aware of all events and activities occurring within the home." We reviewed this person's daily care notes from 1 to 28 July 2017 to identify what activities this person had been offered and what they had participated in. Between 1 and 18 July no activities were recorded; on 19 July this person joined in another person's party and on 24 July they sang karaoke with other residents. On 25 July they watched another person bake a cake and on 28 July they did some art work and joined in some games. There was no

information in the care plan that this person had shown an interest in baking, singing or art work. This person should have been receiving the sole support of one member of staff as identified in their care plan; however their records did not reflect any personalised care or time spent with staff.

In the Provider Information Return, the registered manager stated "Clients fully involved and autonomous regarding care planning", however we found no evidence people had been involved in planning and agreeing their care plans. One person told us they had not seen their care plan.

Failure to ensure people received care and support that is appropriate to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not respond to or record complaints well. On 18 July 2017 one person made a complaint about a member of staff. We asked to look at the service's record of complaints; however a centralised record was not kept. Staff told us that if issues of concerns were raised these were identified on an individual's computerised records. We checked the records for the person who made the complaint and saw this had been recorded, and action had been taken to speak to the staff member involved. However, in the evening of 18 July, the same member of staff was allocated to support this person. This caused the person to become very distressed and as a result staff threatened them with being "put on red". On 19 July this person was restricted from watching the television as a direct result of becoming distressed the previous evening, despite records showing that they had a "good morning". The management team had failed to consider the effect of having a member of staff whom the person had complained about supporting them.

During the inspection on 25 July 2017, another person told us they were unhappy with their care. They said they had told the management team of this however no complaint was formally recorded. As centralised records were not being kept, the service was unable to monitor the quality of support provided or to identify if there were any themes to the concerns raised.

Failure to investigate and take appropriate action in response to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The provider and registered manager failed to ensure the systems and processes in place were effective in ensuring the service is compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had failed to ensure people were supported and staff training in line with current best practice in relation to managing complex mental health needs and positive behavioural support. There was insufficient management oversight to ensure people received the care and support they needed, and for which the service had been contracted for, in a way that protected people from harm and abuse, promoted their wellbeing and independence in a respectful and dignified way. In the Provider Information Return, in relation to the management of the service, the registered manager stated "Excellent Management synergy" without providing a description of how they managed the service. The registered manager told us they visited the service regularly and was able to review the computerised records and CCTV remotely if necessary. We found that although the service had policies and procedures in place in relation to restraint and restrictions and the use of the traffic light system, staff were not adhering to the principles identified within these.

The provider and registered manager failed to assess, monitor and mitigate the risks to service users' health, safety and welfare. The provider and registered manager were unable to provide us with evidence they had analysed behavioural incidents or reviewed CCTV records at times of significant incidents. Analysis is important to identify the circumstances under which people became self-injurious or aggressive towards others to enable people's support plans to be more reflective of people's needs to mitigate risks. During the inspection we identified a number of breaches of the regulations including those relating to a safe environment, protecting service users from harm and improper treatment, mitigating risks to service users health and safety, insufficient staffing levels and the quality of information and guidance contained within service users' care and support plans. Lack of oversight of staff practices within the home failed to identify the restrictive and punitive practices employed by staff to manage people's behaviour.

As a result of our findings during the inspection and the interim outcome of the safeguarding process, it was recommended the provider appointed a Care Consultancy Service to support the management team. The provider agreed to this and confirmed to CQC that the consultancy service would commence at Georgian Annexe on 7 August 2017. However, due to the significant concerns raised over people's safety and well-being we asked for the consultancy service to commence without delay and they were appointed on 31 July 2017.

On 4 August 2017, we imposed conditions on Georgian Annexe (Torquay) Ltd registration which included preventing Georgian Annexe from taking any new admissions, to ensure staffing levels were as contracted, to ensure the service met fire safety regulations and to report weekly to CQC the actions taken by the provider and the Care Consultancy Service to ensure people's safety.

At the time of the inspection, 12 people, one of whom was a younger person under the age of 17years, lived at the service. The service's registration with CQC did not support the admission of people under the age of 17years. Following the inspection, this young person was moved to alternative care provision.

The provider and registered manager were supported by three other senior managers with specific responsibilities, such as medicines management and care planning. On 25 July 2017, the registered manager told us they delegated the responsibility for writing people's care plans, risk assessments and the traffic lights system to a member of this management team. We looked at this member of staff's experience and qualifications to support them in this role. The staff's application form and training records showed they had no experience working with people with mental health needs before applying to work at Georgian Annexe. They had received no specialist training in positive behavioural support since their appointment to this senior position. This meant that people with complex support needs had support plans written by a member of staff with no specialist knowledge.

Staff told us there was a handover report between one shift and the next. However, they said this could be improved as they did not always receive thorough information about people as "staff want to leave early". They said some staff talk about how the shift has affected them rather talk about the people they were supporting. Staff said they refer to a board in the office to identify people's wellbeing as the colour they have been assigned through their traffic light system was identified on the board.

Failure to ensure the service is managed in a way that meets people's needs in a safe way, provides staff with the information and guidance they need to undertake their role, and to monitor the effectiveness and quality of the care provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service is obliged to notify CQC of any incidents of abuse or of injuries to service users which, in the reasonable opinion of a health care professional, requires treatment by in order to prevent the service user from experiencing prolonged pain or prolonged psychological harm. The provider and registered manager failed to notify the CQC of such incidents. For example, records for one person showed that on 16 and 17 July 2017 they physically assaulted two other people living at the service. On 21 July 2017, one person attended hospital with a significant injury. No statutory notification had been sent to CQC in relation to these incidents.

Failure to notify CQC of significant events at the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

Staff told us the vision and values of the service were to provide a family atmosphere and support people with dignity and respect. We looked at the information staff were provided to at the start of their employment at Georgian Annexe. With the exception of a copy of Skills for Care Code of Conduct for healthcare Support Workers and Adult Social Care Workers, there was no information for staff about the service's aims and objectives, its values and how it expected staff to support people. Staff said they enjoyed working at the service and their comments included, "I love it here", "The team is a really strong team", "[staff] are doing a brilliant job" and "I feel massively supported by everyone". They described the on-call system for out of hours support as being very good with easy access to a member of the management team. One staff told us the management team were responsive to requests and gave an example of staff being relived more frequently when supporting people with the most complex care needs.

Staff and people told us meetings were held periodically to review the service and share people's views. A number of 'family rules' had been suggested and agreed by people to support respectful group living. These rules were seen around the service and included, "no pjs downstairs on a weekday", "do not hurt others" and "contribute positively towards the house". We were provided with copies of the minutes from the resident meetings in October 2016 and February 2017, and the staff meeting from April 2017. In both residents' meetings, people had asked about their choices of meals and what social activities they wished to

be involved in.

Following this inspection we asked the registered manager and provider for an urgent action plan to be put into place to mitigate the immediate and serious risks to people's safety and wellbeing we had identified. This was received on 3 August 2017.The provider had also met with the Trust in relation to the 'whole service' safeguarding process and gave assurances of their willingness to work with the Trust and CQC to improve the service.