The Drive Care Homes Limited

Glover House

Inspection report

Glover Road
Willesborough
Ashford
Kent
TN24 0RZ

Website: www.drivecarehomes.co.uk

Date of inspection visit:
14 November 2017
16 November 2017

Date of publication:
31 January 2018

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

The inspection took place on 14 and 16 November 2017 and was unannounced.

Glover House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Glover House is registered to accommodate care and support for up to eight people. At the time of the inspection there were three people at the service.

The service had a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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 service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion.

People with learning disabilities and Autism living at Glover House were not supported to live as ordinary a life as any citizen. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support an empowering, inclusive culture. Doors were kept locked so people could only access lounges and toilets and could not go outside into the garden freely. These restrictions had not been reviewed to check they were still needed.

There was a culture of staff being in control and staff 'did for' people rather than with them. Staff had low expectations of people's potential to achieve and develop. Staff had received training and had supervisions but this had not been effective in equipping them for their roles.

People, and others, were at risk of harm as staff did not support them to manage their behaviours safely. Staff used restrictive physical intervention that had not been agreed to by people and those involved in their care. Physical intervention had not been assessed as necessary or as a last resort. Some people had one to one or two to one support and staff were in close proximity to people at all times. For most of the time staff did not engage or interact with people in a meaningful way they just followed them around. We did observe some meaningful interactions when staff sat with people and involved them in jigsaw puzzles or games. Risks were being managed by controlling and containing people rather than by empowering them. Staff did not recognise, concerns or incidents or near misses. When things went wrong lessons had not been learnt.

Accidents and incidents were not analysed to look for trends or ways of reducing them. There had been

incidents when people had been harmed or were placed at risk of harm. The registered manager had not reported all of these incidents to relevant authorities so they could be followed up or investigated. They had not informed the local safe guarding team of incidents of abuse. Services that provide health and social care to people are required to inform CQC of important events that
happen in the service. CQC check that appropriate action had been taken. The registered manager had not submitted notifications in an appropriate and timely manner and in line with guidance

People's needs were assessed before they moved into the service and each person had a care plan. Care plans were written for people and not with them or their family /representatives. Care and support did not always reflect current evidence-based guidance, standards and best practice. Personal goals and aspirations were not identified, recorded and supported; the principles of person centred care were not used and not understood. People did not have end of life plans in place.

Some staff lacked understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Decisions had been made on people's behalf without considering the least restrictive option and there was no record of any best interest meetings regarding these decisions.

Staff sought advice when people were unwell. People had the food and drink they liked but were not involved in food shopping or food preparation. Activities on offer were limited and staff did not have the skills to develop people's everyday life skills including cooking, cleaning and shopping. People's medicines were managed safely.

There was a complaints procedure and action had been taken to resolve complaints. However, people were not supported to air their views and opinions. The complaints procedure was not in a format that people could understand. People were not involved in developing the service. Relatives and staff had been asked their opinions about the service but no analysis or action had been taken as a result.

There were enough staff but they lacked the skills required to give good support. there were recruitment procedures in place. The building was fitted with fire detection and alarm systems. Regular checks were carried out on the fire alarms and other fire equipment to make sure it was working. The staff carried out regular environmental and health and safety checks to ensure that the environment was safe. The service was clean and well maintained. Staff understood about infection control and how to keep the risks of infection to a minimum.

The governance arrangements including the checks and audits had not picked up the range of issues found at the inspection. The culture of staff being in control had not been identified and so it continued. There was a lack of oversight of staff practice, incidents and accidents, staff were not observed and given feedback. Audits carried out some time ago had unmet actions.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating at the service and on their website

After the inspection the provider told us that they had employed a consultant to give them advice and that they had started to research providers of Positive Behaviour Support and Active Support training for staff.

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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of the report.

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's behaviours were not managed safely, putting people and staff at risk of harm.

People were not fully protected from harm and abuse. Incidents of abuse had not been reported to out-side agencies. Staff used restrictive physical interventions that had not been agreed and assessed as necessary.

Lessons had not been learnt and improvements not made when things had gone wrong. Imposed restrictions had not been reviewed.

People received their medicine as prescribed by their doctors.

There were enough staff on duty bit they lacked the skills to give food support. Recruitment procedures were in place.

The service was clean and there were measures in place to prevent the spread of any infection. Safety checks had been regularly undertaken and the premises.

Is the service effective?

Inadequate

The service was not effective.

Care and support did not reflect current evidence-based guidance, standards and best practice.

Staff training and supervision had not been effective in equipping staff for their roles.

Staff were unclear about the Mental Capacity Act and Deprivation of Liberty Safeguards. Decisions had been made on people's behalf without involving them and considering less restrictive practices and whether it was in people's best interest.

People were supported with their health care needs but were not supported to take more control of their health and well-being.

Is the service caring?

Inadequate

The service was not caring.

Staff were in control of the environment, not people. Areas of people's home were locked and people could not access their kitchen.

There was a lack of accessible communication in place for people who had difficulty communicating verbally. Staff had not received the appropriate guidance or induction to engage with people in a meaningful way.

There were no plans in place to increase people's independence.

People and their representatives/ advocates were not fully involved in developing their care plans.

We observed some kind and caring interactions between staff and people.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person centred care. Goals and aspirations had not been identified and there was no evidence that people's lives were improving.

There was a lack of meaningful activities and staff lacked the skills to engage people in activities throughout the day.

There was a complaints procedure but people were not supported to air their views and opinions and to make complaints.

End of life care plans were not in place.

Is the service well-led?

Inadequate

The service was not well-led.

The registered persons had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service. Management and governance was not effective.

There was no clear vision or strategies in place to promote a positive culture and deliver quality care and support. The service was not person centred, inclusive or empowering.

People were not involved in developing the service. Relatives and staff had been asked their opinions but no analysis or action had been taken as a result.

Systems for monitoring the quality of care provided were not effective. Audits had not identified shortfalls

Incidents had occurred which by law the Care Quality Commission (CQC) should be notified about, but this had not happened.

Accidents and incidents had been recorded but not investigated or analysed to ensure action was being taken and to reduce the risks of further events.

Glover House

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted by information of concern we received from a whistle blower, relatives, the police and the local authority.

This inspection took place on 14 & 16 November 2017 and was unannounced and was carried out by two inspectors.

The provider had not had the opportunity to complete a Provider Information Return (PIR) as we brought this inspection forward after receiving concerns. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received from the local authority and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

Before and after the inspection we spoke with the local authority safeguarding team and the police. We spoke with or spent time with three people. We spoke with the registered manager, the deputy manager, the provider and the head of care for the company. We also spoke with five members of staff and one relative. After the inspection we spoke with another relative.

We looked at three people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance audits.

We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experience of care at the service so we spent time observing them in the communal areas.

We last inspected in August 2016 when there were no breaches of the regulations and the service was rated as 'Good'.

Inadequate

Is the service safe?

Our findings

Relatives said, "I think (my relative) is safe with staff, but not sure if they are always safe from other people in the home".

Some staff told us that on the whole they were able to deal with people. One staff member said. "It's better now we have more men on the staff team. It has been difficult for the girls to manage when there are behaviours" and "Sometimes staff are frightened, especially when they are new".

Visiting professionals had raised concerns with us about people's safety and how risks were managed. They raised concerns about how behaviour was managed and reported the atmosphere was one of staff being in charge and quite 'controlling.'

Some people could become angry and upset and show behaviour that challenged, posing a risk to themselves and others. Some people were subject to restrictive physical intervention or restraint. The provider explained that staff were trained in 'Team Teach' which is 'de-escalation and positive handling training.' Team Teach requires that all restraint techniques are risk assessed, agreed to, continually monitored and evaluated. Any form of restrictive physical intervention (RPI) or restraint must be fully assessed as being necessary, agreed to in advance by all involved, including people's loved ones and supporting professionals. The RPI should be described very clearly- step by step in writing and/or pictures and any use of RPI recorded in writing so that the method of physical intervention, the circumstances when it was used and for how long can be monitored and, if necessary, investigated and reviewed to make sure it is still necessary. There must be de briefs after each use to make sure it was only used as a last resort and used effectively and safely. This process was not being followed which placed people at risk of harm.

There were no assessments relating to the use of RPI and no consent or agreement from all involved recorded for its use. Records showed and we saw that staff were regularly using RPI. We saw staff on both days of the inspection holding people by the wrist and arms, preventing them from going into certain areas; staff used their bodies as physical barriers in doorways to prevent entrance and exit from rooms and to block the stairs. Records showed that there had been 55 incidents so far in 2017 with no analysis or overview to highlight any patterns or trends for example, that incidents happened at certain times, in certain places or involved certain staff members.

A record of restraint was kept which showed two restraints used in October 2017. The length of time the restraint lasted was recorded. For the first incident this was two minutes, for the second incident on 27 October 2017 the two person 'double elbow' restraint (involved two staff, one either side of the person holding the person's wrist and elbow) was recorded as lasting for 25 minutes. The inspectors judged this hold lasting 25 minutes as excessive and the provider agreed.

The staff member involved in the two recorded restraints in October 2017 had not attended training in Team Teach since March 2014 even though the registered manager said staff must attend the Team Teach training every two years. The registered manager had not reviewed the incidents or evaluated the use of the RPI to

ensure it had been used safely, appropriately and only as a last resort. There was no recorded de brief of the incidents.

There were no step by step guidelines to show staff about the safe use of physical intervention. There was no description or photographs to show how to carry out the different levels of restraint and for how long the restraint should be used for and in what circumstances. The provider had a restraint policy that stated there would be an annual report about the use of restraint, there would be post incident debrief and analysis and that staff using RPI would have high quality specific training. This policy was not being followed.

The provider had a safeguarding policy but there was no copy of the Kent and Medway safeguarding protocol for staff to refer to. This protocol gives staff guidance and advice about what constitutes abuse and what action to take if staff suspected abuse.

There had been some incidents of people having unexplained bruising that the local authority safeguarding team were investigating. We read some incident forms and other records that showed people had either suffered harm or were placed at risk of harm. The registered manager had not taken advice from or reported to the local safeguarding team. Suspected abuse or exposure to a risk of harm should be reported to the Care Quality Commission (CQC) and the registered manager had not done this. Not all staff were aware of what constituted abuse and that they should be reporting it. Incidents involving behaviour that challenged were not being effectively monitored and so continued placing people at risk of harm from physical intervention by staff and at risk of the negative impact from the behaviour of others.

The registered manager and staff did not fully understand their responsibilities to report safety incidents and concerns. We picked up on a number of incidents that should have been reported to CQC and had not been. The registered manager did not have oversight of what was happening day to day and did not have oversight of incidents and near misses. So when things went wrong and incidents occurred no lessons were learnt about how improvements might be made to reduce the risk of re-occurrence.

A person had their own car for staff to take them out in. Staff managed the person's money. Records showed that the person had spent money on petrol for the car. There was a record of when the person had been out in the car but no record/log of the mileage used. The registered manager agreed to put a record book in the car to record the miles travelled by who so it could be tallied with the amount of petrol used.

The provider had not made sure people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The risk assessments showed an exaggerated view of the level of risk posed to people, for example a risk assessment noted that a person could not go into the kitchen as they might 'jump through the window'. The risk was assessed as 'high' even though the person had not attempted to jump through the kitchen window. Another risk assessment noted that there was a high risk of cross infection if you shook someone's hand yet they had no infection and staff regularly shook the person's hand. Risk was not being managed creatively so that people could take part in daily living activities and be empowered. Instead people were prevented from taking considered measured risks with the right support leaving them restricted and without control and autonomy.

Staff were deployed to work with people depending on their size. One person was going out and asked for a certain male member of staff to go with them. They were told that this was not possible as the male staff member needed to stay behind to support others. We asked about this and the registered manager told us "We try to put strong people to support (x). The ladies (staff) are not strong enough or confident to do

(physical intervention) on (x)" There was an assumption that strong male staff were needed to restrain people so restraint had become part of people's every day support rather than only being used as a last resort placing people at risk of harm.

People's needs relating to food and drink were recorded in their care plans. There was an assessment of the risk of choking on food. The risk assessments guided staff to sit with people and prepare their food properly but did not give guidance about what to do if a person actually choked. Staff told us they would slap people on the back if they were choking however, people's needs varied so each person would require a different approach if they were choking. Some people would not tolerate being slapped on the back for example. The registered manager agreed to update the risk assessments.

Throughout the inspection staff told us why people could not take part in everyday tasks rather than thinking about how people could be supported to take part. Staff, including managers, argued why people should not do some things rather than having the opinion that they should think about how they could give the right support for people to achieve. Staff had a low expectation of people's potential due to their disabilities which did not support a culture supporting equality and diversity.

Care and support was not provided in a safe way to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were enough staff on duty they lacked the skills and support to give good support. People were funded for either one to one or two to one support and this was provided. We observed that staff constantly monitored people keeping them under close supervision and if a person moved staff went with them. For some people this meant two staff, one at either side of them as they moved up and down the hallway. There was a lack of regard for personal space with staff saying 'but people will attack' when we pointed out that people may not need two staff by their side at all times. We saw no 'attacks' during our two day inspection. When we asked staff what' attack' meant, staff said 'pull at clothes' so there was an exaggerated view of people's behaviour leading to an exaggerated response by staff which we observed throughout the inspection. A relative told us that their loved ones behaviour could be spontaneous, but without clear analysis of incidents the registered manager had not identified high risk times and situations and tailor the support accordingly.

Staff worked up to 14 hour shifts which were not based on best practice as staff, in this sort of environment, could become stressed and/or tired. The registered manager said she had not reviewed the length of shift that staff worked to make sure it suited people and their needs. The registered manager told us the shift length suited staff and their child care needs.

Recruitment checks were carried out before staff started working with people including a criminal background check and obtaining two written references. We questioned a reference for one member of staff and the provider agreed to check its authenticity.

People received their medicines when they needed them but had not been supported to take any control of their medicines, however small that control might be. There were policies and procedures in place to make sure that people received their medicines safely and on time. Medicines were stored securely, the stock cupboards were clean and tidy, and were not overstocked. Temperature checks were done daily to ensure safe storage of medicines. The records showed that medicines were administered as instructed by the person's doctor. Some medicines requiring special storage and closer monitoring were handled and stored in line with legal requirements.

Some people were given medicines on a 'when required basis' if they presented with a behaviour that was considered challenging or if they were experiencing pain. People were only given their 'when required' medicines for behaviours when they had needed it and as a last resort. There was written guidance for each person who needed 'when required medicines' in their care plan. If people were unable to verbally request pain relief medicine there was clear guidance for staff to follow to recognise the physical signs they may display. Some people required emergency medicine to help them recover from a seizure. Staff had attended training in how to administer the emergency medicine and records confirmed this.

The house appeared clean and smelled fresh. Checks had been completed on equipment to make sure they were safe. There was a fire risk assessment and each person had a personal emergency evacuation plan (PEEP), in place to ensure they could be evacuated safely in case of an emergency. Staff understood the emergency procedure and explained how they would support people. Checks had been completed to ensure that water temperatures were at a safe level to prevent the risk of scalding.

Inadequate

Is the service effective?

Our findings

Staff said that they had received the training and support they needed to do their job effectively. Visiting professionals raised concerns about the competency of staff in supporting people with complex needs. Some staff we tried to speak with at the inspection did not want to talk with us. We asked one staff member if they liked working at Glover House. They shrugged their shoulders and said, "It's OK" and walked away. Other staff said they enjoyed the work even though it could be demanding at times.

People were not supported to receive effective care because care was not delivered in line with current legislation, standards and evidence based-guidance. This included guidance from The National Institute for Health and Care Excellence (NICE). This guideline covers interventions and support for children, young people and adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges, and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life.

The providers restraint policy referred to the 'Code of Practice' relating to the Mental Capacity Act of 2005 but this had not been adhered to and nor had the provider's policy when restraint had occurred. Staff were not aware of best practice when supporting people with learning disabilities and behaviours that could challenge. Staff lacked the skills to promote a good quality of life and positive outcomes for people.

Staff we spoke with and observed talked to us about people 'attacking' others and focused on the problems and challenges people faced rather than focusing on support solutions. Staff told us why people could not do things rather than think about how they could. Staff were not using best practice techniques, known to get good results when used with people who have learning disabilities including person centre planning, active support and positive behaviour support.

We observed numerous occasions when staff stepped in to prevent people doing certain things rather than try to support them. Staff told us one room; the 'library' was out of bounds to people and was always locked. It was only used by the staff because people 'might throw the chairs' they had not thought about removing or storing the chairs safely so people could access the room.

Care and support did not reflect current evidence-based guidance, standards and best practice.
This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Generally people were assessed before they moved to the service. Some people had moved to the service as an emergency so there had not been time to assess their needs. Relatives said that they had been initially concerned about the compatibility of the group of people living at Glover House but it had 'worked out' better than they thought.

During an induction period some staff had completed training related to people's needs including Autism, challenging behaviour and person centred planning. The provider explained and records showed these

courses were one to two hours long and involved the staff member watching a DVD and answering questions. One induction record we looked at showed the staff member had covered four different subjects, challenging behaviour, food hygiene, infection control and Deprivation of Liberty Safeguards in one day suggesting the courses did not contain the detail required for staff to support people effectively.

The induction record was a tick list and did not show how the staff's competency was assessed. Staff lacked knowledge about how to support people living with behaviours that challenged positively and we saw for ourselves that staff lacked the skills to give effective, meaningful support.

Training was mainly through staff watching DVD's and answering questions although some courses including Team Teach and fire awareness were face to face. The provider told us all staff should attend training in restrictive physical intervention (Team Teach) every two years, records showed that some staff had not attended this training at all and for others the training was out of date according to the provider's policy.

Staff practice was not monitored and observed so they were not given feedback about how they might improve their support. We observed staff using their bodies as physical barriers and putting their hands on people to restrain them when this was not used as a last resort. Staff were not engaging and enabling people to do meaningful, fulfilling activities when at service. There was a lack of opportunities for activity which was restricted to puzzles, watching TV and hiding and finding a soft toy in a corridor of locked doors. Staff had not been given feedback to improve their practice by the provider or registered manager.

There was a lack of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff met regularly with a line manager (supervision) and this was recorded. Observation was not used as part of this supervision process so that staff were observed and given feedback about their support.

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 authorisation 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People were constantly supervised and were restricted and prevented from leaving. Due to people's needs their capacity to consent to the imposed restrictions was limited so the provider had applied for DoLS authorisations which had been agreed by the authorities who paid for people's care. Some people were subject to restrictive physical intervention. This had not always been agreed and consented to by people or by others in people's best interests. The use of physical restraint had not been monitored to ensure it was safe and proportionate and part of a person centred support plan.

People who did not have capacity to make decisions about their care and support had moved into the

service without any best interest meetings being held to determine if it was the right place for them to live.

People were not involved in planning the meals, going food shopping, cooking or clearing away afterwards. Staff prepared the meals and passed food to people through a hatch from the kitchen to the dining room. Staff told us it was too risky for anyone to go into the kitchen but had not thought about minimising the risks so people could go into the kitchen. When we asked why a person did not go food shopping we were told they 'had been banned from every shop in Ashford' and 'they will attack people'. Staff had not looked at ways of desensitising people to shops and managing behaviours more effectively. There were no plans to try again or to try different strategies and different shops.

Staff prepared food and drinks for people so they had the nutrition they needed. Staff said that due to their needs people ate alone in the dining room at different times. At other times the dining room was locked and not used limiting people to the lounge areas. The registered manager agreed to review this imposed restriction that they said they had 'inherited' when they took over as the manager.

The environment was restricting and people had not been involved in decisions about their home. There was a garden to the front of the house which people could not access as the front door was locked and only staff had the key. There was a lack of space for activities, for people to see their visitors and space to be alone. People only had access to two lounges on the ground floor as all other rooms apart from toilets were locked including the kitchen, dining room and 'library.'

Staff did not have a clear understanding of the MCA and DoLS and had made decisions on people's behalf without seeking their consent or a less restrictive option.
The environment restricted the liberties of people using the service. People's movements throughout the service were restricted. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were supported to attend health care appointments and encouraged to eat healthily to stay well. Some people went out for walks which they enjoyed but for some people this was infrequent. Staff had worked with health and social care professionals including the local community team to help manage people's health conditions. Staff told us that everyone was registered with a doctor and dentist and theses details were recorded in case staff needed to make appointments. Staff told us the GP visited the service rather than people attending the GP surgery as people might 'attack others.' Again, there were no plans to desensitise people to the GP surgery or thought given to attend at quiet times or work with the GP practice to try to support people to attend.

Staff worked with other professionals including staff at a day service attended by two people one day a week. Staff invited the staff there to contribute to people's review meetings and visa versa so reviews had a view of how people were doing when at the day centre. There was opportunity to develop this further as only two people attended one day a week.

Inadequate

Is the service caring?

Our findings

Stakeholders including relatives, professionals and a whistle blower told us about concerns they had about the way that staff treated people. They told us they thought that some people were not always treated with kindness and respect. We saw some of this practice for ourselves.

One person was very keen to see a member of staff and repeatedly asked staff if they could see them. Staff said no and explained that the staff member was working with another person. The person kept on asking and so we asked the registered manager why the person could not see and say 'hello' to the staff member. The registered manager said because the person 'will attack the staff.' A short time later the staff member in question appeared by the laundry door and the person made their way to them. Two staff intervened to try to prevent any contact, the person touched the staff on the shoulder, a gesture they used to say 'hello'. The staff member did not speak or engage with or speak with the person but turned their back, went back into the laundry and shut the door. The person stood by the door for a moment until distracted to go back to the lounge by another staff member.

Staff did not always spend time with people in a meaningful way, staff were either sitting watching people or waiting for them to move and then followed them. Some staff did not seem very interested in people and did not make attempts to engage or display empathy or concern about people. We observed one person coming out of the dining room; they were not steady on their feet and needed time so they held onto the door frame to steady themselves. A staff member was saying 'come on, let go, let go of the door frame' and seemed to be rushing the person rather than showing patience and giving them the time they needed. The tone of voice of the staff member was one of impatience rather than of patience.

There was a feeling of confinement and restriction. People were not involved in meaningful activities and were not taking part in everyday tasks like cooking and cleaning. People were not supported to take part in keeping the house clean. The kitchen and laundry were locked and we observed no one being supported to take part in any cleaning or laundry activities. There were no plans to increase people's skills regarding cooking, cleaning tasks or laundry. Staff were doing things for people rather than with them. Staff's attitude was that people could not do these things due to their learning disabilities and behaviours. Staff were not using techniques like Positive Behaviour Support and Active Support to really get people involved despite their disabilities. Staff had low expectations of people's abilities leading to limited opportunities for people to achieve.

There was nothing displayed to help give control to people for example, there was no rota with photographs to show people who would be supporting them, there were no ad hoc activities displayed so people knew what was available other than the weekly activity planners that had blocks of four hours of activities. For example, for one person 07.30 am to 10.30 am was for a bath, clean room and laundry. We arrived at 09.15 am and staff said the person had completed these activities. There was nothing more on offer until, while we were observing, staff offered to play hunt the soft toy. There was little scope for this game as only a ground floor corridor with locked doors was available to hide the toy. Staff did engage with this game while we were observing and for a short period of time the person appeared to enjoy it then appeared to get bored with the

game. No alternative game or activity was offered.

Some people had support from their families. No one was currently using the services of an advocate. Staff did not treat people's privacy and dignity as a priority. There was a private room where people could spend time with their loved ones but it was locked and not accessible to people.

Staff, and not people, were in control of the environment. Areas of the service were locked, staff tried to control the rooms that people went into, which were the two lounges. There was no assessment of the environment to determine if this was the least restrictive method of support. Staff told us this was to protect people. People were allocated one to one support throughout the day so there would always have been a staff member present if the rooms had been unlocked.

People were not treated with dignity and respect. People were not supported to be autonomous, independent or involved. People were not receiving person centred support. This was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported to have 'private time' in their bedrooms if they wanted to and staff respected their wishes when they indicated they wanted this. We did observe some positive support, the provider and a member of staff danced along with one person to their favourite music in the lounge. There was laughter and the person looked like they were enjoying it.

Inadequate

Is the service responsive?

Our findings

Relatives said they were involved to a certain extent in their loved one's care and support. One relative told us that their relative's mobility had decreased since arriving at the service and felt this was because of their diet and lack of exercise. They had discussed this with the registered manager and said that action was going to be taken.

Visiting professionals who had worked with people told us that they had worked with staff to help them support people to be more independent and do more for themselves like making drinks but they told us that staff had not continued to follow the guidance.

Another professional told us that people were offered limited activities and staff did not effectively communicate with people.

Although each person had a care plan which gave information about supporting their basic needs there was no mention of any personal gaols or aspirations. The care plans had not been written with people's involvement and were not produced in a way that was meaningful to people. The care plans contained pen portraits, information about people's life history, information about the person's routines and how they preferred to communicate. Care plans also contained individual behaviour guidance and information about how staff could support the person in different situations. However this was not always written in a way that was respectful and in line with best practice. One person's care plan stated that they needed their nails cut regularly, the care plan stated, 'distract by getting the person to hold something', ' wait for them to be in the right mood' it was concerning to find that the last guidance was 'two staff were to hold the person's hands still while a third person cut their nails'. This was restrictive practice that had not been assessed as the least restrictive option and agreed to by everyone involved.

Some of the terminology used in care plans was not respectful for example instead of a continence care plan it was entitled 'urinating and defecating on the floor' care plan. Disrespectful language in records was highlighted at the last inspection and the provider agreed this needed to improve.

Each person was allocated a key worker and co-keyworker who were responsible for conducting key worker sessions. The purpose of the sessions was to allow people to have the opportunity to feedback what was working well for them, how things could improve and what action was required to achieve this. However, there was no record to say what the outcome of these sessions was and what had been identified. Staff were unsure when we asked them about the sessions. People's personal goals and aspirations were not identified or worked towards. Opportunities to achieve small goals like making drinks or going to different places were not supported and opportunities to develop people and increase their quality of life were missed.

People's care plans explained the best way to communicate with them but staff sat beside people or followed them around but did not interact with them. Some staff were uncertain about how to communicate with people who were nonverbal. One person's care plan stated 'support to choose things' but the people were offered limited choices in their daily lives, including where they could go in the service.

Staff told us one of the lounges was used mainly for one person and they tried to keep other people out of there. We saw staff barring the door way into and out of the lounge by standing in the doorway. However we did see the person leave the lounge when they wanted to. Staff did tell how they supported people to choose the food they wanted by offering two choices. Some established staff were able to tell us about how people communicated at certain times, like how they behaved if they were in pain.

We went to one person's bedroom which was bare apart from some pictures on the wall. There was one picture that the person had painted themselves. There were no curtains at the window and no pillows on the bed. The person's clothes were locked in a cupboard. The shower in the person's bedroom had been disconnected. When we asked staff why this was they said that the person 'destroyed everything' and if the water was connected they flooded the bathroom. The staff had not tried to introduce items slowly to see if the person liked and accepted them. The pictures on the wall had not been destroyed.

There was an incident at the service during our visit, when staff overreacted in a panicked way. Three staff rushed into room after a person, they physically tried to stop the person from getting what they wanted. There was a lot of staff speaking loudly and giving different orders which led to confusion and chaos. The situation was not handled in a calm and controlled way and the person's care plan and guidance had not been adhered to.

The staff were working with a care manager and family to develop a positive behaviour support plan for one person. They were in the process of monitoring and analysing behaviours to identify triggers, trends and patterns. The aim was the staff would be able to anticipate and respond in a more proactive way to support and care for the person in the way that suited them best. This was the plan for the future but not yet happening.

Activities for most people were limited. One person said that they would like to do cooking but the kitchen was not accessible and the person had not been supported to cook. Another person's plan said they liked looking at photographs but there were no photographs to look at in the downstairs area. On the day of the inspection a person was supposed to be going to the woods for a walk. When we asked staff when would they be going the staff said, "Not today as they are aggressive". During the inspection the person was not aggressive, the person appeared bored.

Another person's daily records recorded that most days of one month they were 'pacing around the service'. Daily records stated, 'Pacing', 'walking around the house', 'moving from one part of the house to another', 'throwing themselves on the floor'. Only on one occasion throughout the whole month had it been recorded that the person had been offered an activity of going out to the woods and they had done this. The staff were not able to explain why the person had not been out more, except to say the person did not want to go anywhere. There was no record to indicate if the person had been offered a choice about what they wanted to do and no consideration had been given as to why the person had not wanted to go out. When we looked at the records for previous months it was recorded that they had been out and about more. Personal goals were not recorded and supported. Staff were not using best practice techniques including Person Centred Active Support to really develop and increase people's skills.

Some people had visits to their families and some people stayed overnight with their families. Staff drove people to their family home and collected them. One person told us that they liked going to visit their family.

The provider had a complaints procedure. Complaints had been recorded and action had been taken to resolve the complaints. There was no analysis of complaints to identify any patterns and use them to

develop and improve the service. Some people had profound and complex needs and may be unable to make complaints due to their communication needs. Staff had not been trained in alternative methods of communication and in how to support people to air their views and opinions. The complaints procedure was not displayed in a meaningful way to support people to raise issues and concerns.

People's wishes about the care they wanted at the end of their lives should they become unwell was not recorded. This has been identified during an audit dated 6 February 2016 that said 'end of life care plans needed' this has not been done so people's wishes were not recorded

People's care plans did not contain ways of maintaining or increasing people's independence. People's care plans were not adhered to. People were not involved in making decisions about their support and their wishes about end of life care had not been assessed and recorded. people did not have the support they needed to communicate their views and any complaints. This was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Concerns were raised to the Care Quality Commission about the culture of the service in that it was not open, person centred and empowering for people. We saw this for ourselves. The culture was one of staff doing for people rather than doing with them. Staff were in control of the environment and in control of what happened day to day. Every door on the ground floor was locked apart from two lounges; only staff had the key codes to enter these rooms and only staff had keys to leave the building and get out into the garden.

People were not free to move around and to go outside when they wanted to. The registered manager said they had inherited the imposed restrictions and this was what was 'handed over to them'. The registered manager had not reviewed the restrictions, the locked doors and the restraint that was used, to ensure that they remained necessary and that they were the least restrictive option. Staff told us people 'were not allowed' in the kitchen and gave reasons why people should not go in the kitchen rather than thinking about how they could support people to access the kitchen more safely. For example, one staff member said people could not access the kitchen 'because of the knives' but agreed if knives were locked away the risk would be reduced. They then said 'because of the food' but agreed if food cupboards were locked there would be less of a risk.

The registered manager used language like 'they will attack you' when referring to people and had an exaggerated view of risk which led to people being restricted further. Records showed a negative culture and referred to people 'attacking others' when, after looking into this further, it was not the case. The registered manager and deputy manager said on several occasions 'they can't do this, they can't do that' rather than thinking creatively about empowering and supporting people more effectively and positively.

The culture was one of control. We asked about a record relating to a restraint that had lasted 25 minutes which the provider agreed was excessive. In response, the registered manager and deputy manager brought a member of staff to the inspectors and closed the door. The registered manager asked the staff member to explain the restraint was not for 25 minutes as they had recorded and that the record was incorrect. The deputy manager stood at the staff member's side while the registered manager stood in front of the closed door with their arms folded while the staff member explained. The staff member looked uncomfortable and this did not present as an open, inclusive and honest culture.

The registered manager was not skilled in supporting people with learning disabilities and behaviours that might challenge. Staff were not using best practice support techniques including Positive Behaviour Support but were containing people using restrictions including physical barriers. We saw on both days of the inspection staff using their bodies to prevent people leaving the lounge and preventing them from accessing parts of the service.

The registered manager said she did not observe the support staff gave and did not give staff feedback to improve their practice. Some 'spot checks' had been carried out and we saw records of two checks this year by the deputy manager but the focus was on the building/rooms, laundry and paperwork rather than

looking at the care and support that people received. An audit was carried when the auditor did observe staff and reported on how people appeared, this was dated June 2016, there was no further audits including observation of staff practice.

Staff had not been developed to improve their practice and poor practice continued. The governance and audit systems, including the visits and checks carried out by the provider, registered and deputy managers, had not picked up that staff were using controlling techniques and not providing person centred support. There was a lack of observation and oversight of staff practice, staff were not given feedback and so the controlling practice continued. Rather than think creatively and with innovation about how they might support people to achieve and have an improved quality of life with more good days staff gave us reasons and excuses why people could not do things including 'but they have challenging behaviour.'

People were not involved in developing and shaping the service. People met with their key workers to gain their views and opinions however staff lacked the skills to pick up on how people were feeling and what could be changed to improve their quality of life. The registered manager could give no example of an improvement that had been made based on people's views and experiences. They told us, 'we have provided mini bus as that is what staff wanted'.

Staff had completed a questionnaire in October 2017. The completed responses were in a file. There was no analysis or results that had been shared with people, staff and others. There was no learning or development identified even though nearly half of the staff who responded said that they were not satisfied in their role and that they did not have a feeling of personal accomplishment. The registered manager said there was no action plan to improve the service following the survey.

Surveys had been sent to relatives and no responses received. The provider said they were planning to change the survey format to encourage more relatives to respond.

There were no links with the community. The registered manager said one person did not go shopping as they had been 'banned from every shop in the town.' The registered manager had not changed the person's support or worked with local shopkeepers to try to support the person to get use to shops gradually so that they might go shopping again.

There was a lack of learning from incidents and events with no analysis to establish patterns of trends. Some patterns were obvious to inspectors after assessing some incident reports but the registered manager had not picked this up and incidents continued.

The provider had failed to assess, monitor and improve the safety of the service. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to seek and act on feedback from relevant persons. This was a breach of Regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people went to a local day service one day a week. The registered manager and staff invited the service to be involved in people's reviews and vice versa. Referrals had been made to professionals including speech and language therapists. There was opportunity to develop other links, for example in the Provider Information Return of April 2016, the registered manager said they planned to improve links with community services but this had not happened. The registered manager said they had attended a forum group for registered managers to try to network and share ideas with other managers.

There was a lack of transparency, some incidents where people had been harmed or there was a risk of

harm to people had not been reported to the local safeguarding team for advice and some notifications had not been sent to CQC as required. The registered manager did not understand their responsibilities in reporting incidents.

The provider had failed to inform CQC of notifiable events. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating at the service and on their web-site.

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 had failed to inform CQC of notifiable events. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

We placed a condition on the providers registration to undertake monthly audits of the service and send a monthly written report to the Care Quality Commission which includes details of any incidents and accidents and any use of restrictive physical intervention or restraint and what action was taken in response. Confirmation that any use of restrictive physical intervention used has been assessed, agreed to and only used as a last resort.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support did not reflect current evidence-based guidance, standards and best practice. People were not treated with dignity and respect. People were not supported to be autonomous, independent or involved. People were not receiving person centred support. People's care plans did not contain ways of maintaining or increasing people's independence. People's care plans were not adhered to. People were not involved in making decisions about their support and their wishes about end of life care had not been assessed and recorded. People did not have the support they needed to communicate their views and any complaints. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The enforcement action we took:

We placed a condition on the providers registration to undertake monthly audits of the service and send a monthly written report to the Care Quality Commission which includes details of any incidents and accidents and any use of restrictive physical intervention or restraint and what action was taken in response. Confirmation that any use of restrictive physical intervention used has been assessed, agreed to and only used as a last resort.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and support was not provided in a safe way to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We placed a condition on the providers registration to undertake monthly audits of the service and send a monthly written report to the Care Quality Commission which includes details of any incidents and accidents and any use of restrictive physical intervention or restraint and what action was taken in response. Confirmation that any use of restrictive physical intervention used has been assessed, agreed to and only used as a last resort.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not made sure people were protected from abuse and improper treatment. Staff did not have a clear understanding of the MCA and DoLS and had made decisions on people's behalf without seeking their consent or a less restrictive option. The environment restricted the liberties of people using the service. People's movements throughout the service were restricted. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

We placed a condition on the providers registration to undertake monthly audits of the service and send a monthly written report to the Care Quality Commission which includes details of any incidents and accidents and any use of restrictive physical intervention or restraint and what action was taken in response. Confirmation that any use of restrictive physical intervention used has been assessed, agreed to

and only used as a last resort.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the safety of the service. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to seek and act on feedback from relevant persons. This was a breach of Regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We placed a condition on the providers registration to undertake monthly audits of the service and send a monthly written report to the Care Quality Commission which includes details of any incidents and accidents and any use of restrictive physical intervention or restraint and what action was taken in response. Confirmation that any use of restrictive physical intervention used has been assessed, agreed to and only used as a last resort.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We placed a condition on the providers registration to undertake monthly audits of the service and send a monthly written report to the Care Quality Commission which includes details of any incidents and accidents and any use of restrictive physical intervention or restraint and what action was taken in response. Confirmation that any use of restrictive physical intervention used has been assessed, agreed to and only used as a last resort.