Mr Stephen Antony Campbell

# The Beaches

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on the 5 and 6 December 2016 and was unannounced. The Beaches provides accommodation and support for up to four people who may have a learning disability or autistic spectrum disorder. Some people display behaviour which may challenge others. At the time of the inspection four people were living at the service. All people had access to a communal lounge/dining area, kitchen, shared bathrooms, and laundry room. There was a large garden which people could access when they wished. One person had access to an additional room upstairs where they watched television or listened to music which they called The Den.

The service provider, Mr Campbell, also works as the manager. Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were unaware of the safeguarding processes to follow if they needed to report any concerns outside of the organisation, a safeguarding policy was not available for staff to refer to.

Safety checks had not identified the risks of fire doors being propped open. Individual personal emergency evacuation plans (PEEPS) lacked enough information to inform staff how people should be supported in the event of a fire.

The processes for auditing medicine and making improvements when errors were made were not robust. The medication administration record (MAR) sheets showed all required medicines were in stock and people had received their medicines as prescribed. Staff stored medicines securely in a lockable cabinet.

Accidents and incidents were recorded but the provider lacked good oversight of incident management. Risk assessments had not been updated when people had been identified as being at risk. The provider had not done everything reasonably practical to reduce the risk of harm to people.

People were not protected from robust recruitment procedures, the provider could not demonstrate how they ensured the staff they employed were suitable for their roles.

There was no system in place for staff training to be monitored, we were unable to assess the training staff had received and when they had received it. Induction processes did not adequately prepare new staff to complete their roles. It was not possible to see if all staff had received regular supervisions. We asked the provider to send us information after the inspection relating to training and supervision but did not receive any.

The provider did not have a good understanding of the process they should follow to comply with the Mental Capacity Act. The provider was not working within the principles of the Act.

Care plans lacked enough person specific detail which meant people may be at risk of receiving inappropriate support. People's behavioural guidelines lacked enough information to guide staff to manage incidents well.

Information recorded about people did not always demonstrate staff were respectful or compassionate about the person's individual needs.

The provider lacked oversight and improvement was not driven. Some feedback was obtained with the view of improving the service, but action was not taken or recorded to demonstrate the improvements that had been made. The provider had not kept accurate or complete records to support staff to deliver safe care and treatment to people.

There were suitable numbers of staff on shift to meet people's needs. Staff demonstrated a good understanding of how to support people well.

People had choice around their food and drinks and staff encouraged them to make their own decisions and choices.

People's healthcare needs were managed well and people were supported to access outside health professionals when they needed this.

Staff demonstrated caring attitudes towards people and showed concern for people's welfare. People were treated with dignity and respect and staff interacted with people in an interested and compassionate way.

People were supported to attend activities and day trips outside of the service and were offered various activities within the service.

People had access to an easy read complaints policy in their care files. A relative told us they knew how to complain and were confident the provider would act on any concerns raised.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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?

**Requires Improvement**

The service was not consistently safe.

Safety checks had not identified areas of risk around the service, plans to support people in emergency situations lacked detail.

Medicine monitoring was not robust in identifying errors and staff were not rechecked for competency after making errors.

Safeguarding information for staff to refer to was unavailable and staff did not have a good understanding for the process of reporting incidents.

Incident and accidents were not robustly monitored by the provider.

There were enough staff to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Training and supervision information was unavailable and the provider did not have an adequate system in place to monitor this.

The provider did not have a good understanding of the process they should follow to comply with the Mental Capacity Act.

People had been supported to attend health appointments when this was necessary.

People had choice around their food and drinks.

### Is the service caring?

**Good**

The service was caring.

Staff spoke to people in a kind and patient way. Staff took the time to interact with people and engage them with activity.

Staff took the time to listen to what people were telling them.

People's bedrooms were decorated in a personal way.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care plans lacked enough person specific detail which meant people may be at risk of receiving inappropriate support.

People's behavioural guidelines lacked enough information to guide staff to manage incidents well.

People were offered varied activities to meet their individual needs and interests.

There was a complaints procedure available for people should they be unhappy with any aspect of their care or treatment.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The service lacked oversight and improvement was not driven.

There were no internal systems for monitoring the quality of the service. The provider had not identified any of the concerns found at this inspection.

Relative's feedback was sought so improvements to the service could be made but action was not taken or recorded to demonstrate how the service had improved.

# The Beaches

**Detailed findings**

## Background to this inspection

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

This inspection took place on the 5 and 6 December 2016 and was unannounced. The inspection was conducted by one inspector. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to tell us about by law. The provider had not had the opportunity to complete a Provider Information Return (PIR) as they had not received this document before the inspection. 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 collected this information throughout the inspection.

During the inspection we spoke with three people, one relative, two staff, two deputy managers and the provider who also manages the service. Before the inspection we received feedback from two healthcare professionals, after the inspection we received feedback from one relative and one healthcare professional. Some people were not able to express their views clearly due to their limited communication. We observed interactions between staff and people. We looked at a variety of documents including four people's support plans, risk assessments, activity plans, daily records of care and support, three staff recruitment files, medicine administration records, and quality assurance information. We asked the provider to send us some information after the inspection which we did not receive.

This was the first rated inspection for the service since the providers registration changed to an individual in May 2016.

Requires Improvement

# Is the service safe?

## Our findings

A relative said, "I've been happy (relative) gets safe care, the staff are very good. I feel well informed, we get phone calls often and told how (relative) is"

Staff showed a basic awareness of different forms of abuse, but were unable to describe the correct processes to follow if they needed to report abuse to external professional bodies. The provider did not give us any information about the training staff had received in this area. The service did not have a safeguarding policy in place that staff could refer to, the provider said there had been one but they did not know where it had gone. During the inspection a copy of the safeguarding policy was obtained from the providers other service. The service had a whistleblowing policy in place and staff understood how to whistle blow if they had concerns around peoples safety, the provider told us that they did not use restraint at the service.

Accidents and incidents were recorded but the provider lacked good oversight of incident management. There were copies of incidents on peoples care records and separate accident books for people and staff. We were unable to read some of the recorded incidents because they had been poorly recorded. We asked the provider to read us the information recorded and they also struggled to do this. One incident should have been reported to the local authority safeguarding team. The provider had not done this; we informed the local authority about this incident after the inspection. We asked the provider how they monitored incidents and accidents, they told us that staff phoned them if they were not at the service to inform them but they did not have a formal monitoring system in place to identify patterns, or trends.

The provider had failed to have proper systems and processes in place to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the behaviours described in incident reports were not highlighted in peoples care files meaning staff did not have information reflective of people's current needs. One staff told us that a person had 'time out' when their anxieties increased; there was no reference to this in the persons care file. We asked the deputy manager what this meant who said this was not the correct term to use. They explained that the person was supported by staff to have a space away from others to relax and decrease their anxieties. The provider said, "Normally staff phone me and tell me what's happened and I verbally tell them (what to do). But I agree we need better oversight of incident and accidents and show how we put things in place to improve". We recommend that the provider introduces a monitoring system to provide better oversight.

People were not protected from robust recruitment procedures. One staff members Disclosure and Barring Service (DBS) check was obtained after their start date. DBS checks identified if prospective staff had a criminal record or were barred from working with adults. The DBS identified the staff member had a criminal record. The provider said they had prolonged the probationary period for this staff member but there was no information on the staff members file to demonstrate this. The provider had not completed any further risk assessments around the suitability of this staff member's appointment. From the three staff recruitment files viewed one staffs employment history had not been explored for gaps. The dates they had given on

their application form for their previous employment did not match the dates their previous employer gave. Another staff member's file was missing identification. The references obtained for one staff member were obtained either after they had commenced work, or on their start date. Another staff members references were undated or were dated four years prior to them commencing work. The provider could not demonstrate how they assessed the suitability of two staff members' health to determine they were able to complete their role effectively. This left people at risk of harm because the provider had not made all the appropriate checks to ensure staff were suitable for their role.

The lack of effective and safe recruitment processes is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's processes for auditing medicine were not robust. An errors sheet was used to identify if staff had made any errors while administering medicines. However, further training or learning from mistakes was not implemented by the provider. Audits did not include assessing patterns to determine if the same staff repeatedly made errors. Staff who had made errors were not competency checked or offered additional training before continuing to administer medicines. Audits on medicines were conducted monthly but recordings of audits were not made which meant it was not possible to see how the provider learnt from errors or improved practice. Checks on loose or boxed medicine were not regularly completed which meant if mistakes occurred it was not possible to track when the error happened and which staff member was at fault. Although the medication policy had been reviewed in October 2016 the policy had been implemented in March 2003 and did not contain the most recent best practice guidance.

Staff administered medicines for all people living at the service. The medication administration record (MAR) sheets showed all required medicines were in stock and people had received their medicines as prescribed. Staff stored medicines securely in a lockable cabinet.

The provider had failed to have robust management of medicines. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had not been updated when people had been identified as being at risk. For example, a person had fallen down the stairs whilst having a seizure. The risk to the person had not been reduced and no action had been taken to implement measures to minimise the outcome of harm the person could suffer. The deputy manager told us that the incident had been discussed but recordings had not been made of how they could prevent similar incidents occurring again. Other risk assessments had been implemented to reduce the risk of people being harmed and staff were able to describe how they supported people to remain safe.

Fire risk assessments had been made by an external consultancy firm. We found a person's bedroom door propped open by a door wedge which did not comply with fire regulations and was a risk to the person's safety. The provider said people did not normally prop their doors open although door wedges were found next to each bedroom door and The Den. We asked the provider why Doorguards or equivalent safety devices had not been fitted and they said they did not know this was necessary. A Doorguard is a device which will automatically close an open door if triggered by a fire alarm. This posed a risk to peoples safety should a fire occur.

Some people may need help and assistance to leave the service in the event of an emergency evacuation. Individual personal emergency evacuation plans (PEEPS) should establish people's support needs and how they may respond to an emergency situation; staff should be aware of these support needs. PEEPS lacked enough information to inform staff how people should be supported in the event of a fire. One person's

assessment stated, '(Person) would not follow instructions and would need full support to be moved'. There was no further information of how moving the person could be achieved, which placed the person at risk. Another person's PEEP said, '(Person) will wonder and will need constant prompting and physical guidance as they will panic and move back to where they feel safe. (Person) will not be co-operative but will not get aggressive'. There was no further specific information to describe how staff should physically support the person in this situation.

The provider had not done everything reasonably practical to mitigate the risk of harm to people. The provider had not ensured the premises was safe for people to use and had not provided appropriate equipment. This is a breach of regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not developed any contingency plans should there be a disruption in the delivery of the service or if there was an emergency situation. We recommend that the provider introduces a process for staff to refer to should an emergency situation arise.

Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment. This included weekly and monthly checks on the fire alarm system, fire extinguishers, emergency lighting, gas safety checks, checks on electrical installation, and portable appliances.

There were suitable numbers of staff on shift to meet people's needs. Two staff were available from 8am until 8pm, during the night two wake night staff were deployed. We looked at staff rotas for October, November and December 2016. Rotas confirmed the staffing numbers the provider told us were in place. The provider told us that staffing levels were flexible if required, for example if extra staff were needed to support people to any appointments or special events, additional staff from the providers other service could be used. Agency staff were not used by the service, if there were gaps in the rotas due to sickness or annual leave the provider or staff worked overtime to provide the required support. Staff demonstrated they had the skills and knowledge to support the individual needs of people in their care. They provided appropriate assistance for people with personal care, eating meals and getting ready to attend activities. They spent time talking to people and did not rush them when providing support. The provider and two deputy managers had implemented an on call system to ensure staff always had a point of contact should they require support or emergency assistance.

Requires Improvement

# Is the service effective?

## Our findings

There was no system in place for staff training to be monitored, we were unable to identify the training staff had received and when they had received it. There was a document on the wall of the office displaying names of staff and a list of mandatory training which indicated if staff had achieved qualifications. The list was not dated so it was not possible to see if the training was current. The provider had a folder of certificates of training that staff had completed but could not provide accessible details of when staff had obtained qualifications and when they needed to be renewed. We asked the provider to send us evidence of current staff training after the inspection which we did not receive. Staff told us they did receive regular training although one staff member said they sometimes had to assist a person off the floor but they had not received practical moving or handling training. Staff demonstrated they could support people with their individual needs well; during the inspection a person suffered a seizure which staff responded to quickly and appropriately.

Induction processes did not adequately prepare new staff to complete their roles. The provider told us that new staff members shadowed other staff for a few weeks before working as a full member of staff. They were then observed by a senior staff member to confirm competence; records of these competency checks were not kept. The provider did not use The Care Certificate to assist with staff induction. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. The deputy manager said, "We don't do The Care Certificate or keep records of observations made of staff. They just complete an induction checklist". Although we were able to view some induction information in staff recruitment files this information consisted of a two sheet checklist that staff ticked off to confirm they understood policies relating to the service. The information did not demonstrate how the provider had assessed that staff member's competency or skills were appropriate to be able to deliver care and support to people.

The provider said since they had taken over managing the service in May 2016 all staff had received one supervision. Staff files were not held at this service but were stored at the providers other service so we were unable to view records of supervisions and appraisals. We asked the provider to send us evidence of the supervisions and appraisal staff had received after the inspection which we did not receive. The provider said that formal supervisions were an area that needed to improve although staff could contact the provider or deputy manager should they need any support. Supervisions are an important part of monitoring a staff member's development and training needs as well as an opportunity for staff to discuss issues relating to their role and progression within the service.

Staff had not received appropriate training and support to enable them to carry out the duties they are employed to perform. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were encouraged to gain qualifications in health and social care while working at the service. Seven staff had obtained a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To

achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

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 make particular decisions, any made on their behalf must be in the best interests and as least restrictive as possible. 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

Staff had awareness of the MCA but required further training to fully understand how to comply with The Act. The provider said one standard authorisation application had been made prior to them taking over the management of the service in May 2016. They had not followed up to see if the authorisation was being processed, nobody was currently subject to a DoLS authorisation although restrictions had been placed on people's freedom in certain aspects of their lives. For example one person was prevented from accessing certain parts of the service without staff supervision due to their epilepsy and because they frequently touched things which could pose a risk of harm to them. Certain restrictions had been placed on people in regards to simple everyday decisions. For example, one person required an audio monitor in their bedroom through the night so staff could be alerted if they had any seizures. This person was also missing capacity assessments for restrictions whilst using their wheelchair; in the form of a lap belt and a belt used to help guide the person to their wheelchair when going outside of the service.

Capacity had not been assessed to see if people were able to make decisions themselves and a best interest process had not been followed to determine if the restriction imposed on people was the least restrictive option available. One person's medicine was being crushed and administered to them covertly in their drink. This method of administration had been agreed with their GP, relatives and staff but there was no documentation on the persons care file to demonstrate the person's capacity had been assessed or they had been consulted. The provider did not have a good understanding of the process they should follow to comply with the Act and told us they did not realise they needed to assess people for less complex decisions. The provider was not working within the principles of the Act.

The registered person had not acted in accordance with the requirements of the Mental Capacity Act 2005. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative said, "Last year (relative) was distressed, staff had picked this up, we think they were in pain. They are very good at referring to medical professionals or the nurse attached to the disability team". People were registered with their own GP and supported to attend appointments when necessary. Staff told us they knew people and their needs very well and could recognise if someone was not well. Guidance was available for staff to support people with managing particular health conditions such as epilepsy. Guidance did not specify when a person required occasional medicine (PRN) to help them manage their seizure activity although staff were able to describe the actions they could take to support the person during these times. This is an area that needs to improve. People had access to various outside professionals, such as dentist, psychological services, neurology and occupation health.

A person said, "I had chicken korma last night, I chose it, it was nice". People were involved in planning the

menus and preparing meals with staff support. People went shopping with staff each week and chose different things they wanted for their meals. Each day a person chose what the meal would be, if people wanted an alternative this was catered for. There were menus that reflected what we had been told. Meal times were a social occasion when everyone came together around the dining table and talked about their day. Throughout the inspection people were offered a choice of hot or cold drinks by staff, each person had a snack box should they want additional food in between meals.

Good

# Is the service caring?

## Our findings

A relative told us that the provider went out of their way to help their relative remain in contact with them. The relative told us the provider had arranged for a staff member to bring their relative home for a visit. This really helped them out as it allowed the visit to remain relaxed and staff were able to tend to the persons personal care which took the strain off the relative so they could enjoy the visit more. Another relative said, "I'm happy with my relatives care, they have no problems. I'm not concerned at all and am happy with the care".

Some people were unable to tell us directly of their experiences but we were able to observe a number of examples where staff showed a caring and compassionate attitude towards people. A staff member spoke to a person about cleaning out the cage of their pet and praised their efforts when they said they had completed the task. Another person had attended a sensory session, when they returned to the service the staff supporting them told us the person had enjoyed their session and described particular parts of the session that the person had engaged with well and enjoyed. The staff member demonstrated they were interested in the person's enjoyment of the activity although the person was unable to verbally feed this back. The staff member spoke about the person in a caring and positive way.

During the inspection staff continually engaged with people and included them in conversations. They frequently asked people if they were okay and if they were happy or needed any support. One person was watching a film on the television and shouted out at one of the scenes where actors were fighting. A staff member asked immediately if the person wanted the television turned over but the person responded they were enjoying the film. Staff respected people's rights to make their own choices. One person liked to have a lay in some mornings and staff respected this was the persons wish, another person liked to take naps on the settee in the lounge which they did freely throughout the inspection.

One person showed us their bedroom and told us that they liked their personal space and decorated their room how they liked. The person said that they could use The Den if they wanted space away from other people. Other people's bedrooms were decorated in a personal way and they had many objects such as stuffed toys, photographs, ornaments, DVDs, CDs, and pictures to make their rooms feel homely and comfortable. People appeared relaxed and happy in the service and staff respected people's privacy and asked for permission before entering their personal space; people had access to advocacy service if they needed this.

One person was not feeling well throughout the inspection, staff frequently checked on the person to see if they needed anything and if they were feeling better. Another person had recently undergone a medical procedure and staff were mindful that the person may be unsteady on their feet so extra vigilance was taken when the person was walking around the service. Staff were always close by to the person in case they needed support.

People could have visitors when they wanted to and there were no restrictions on what times visitors could call. People were supported to have as much contact with their friends and family as they wished, two

people regularly went out with their relatives either weekly or every other week. A relative told us they could visit whenever they liked and staff were always welcoming and accommodating.

Requires Improvement

# Is the service responsive?

## Our findings

A person said, "I'm going to Phase two today, I have friends there I like it. I can talk to staff if I'm unhappy, I like dancing and singing. I stroked the reindeers at the reindeer centre last week, I like animals". A relative said, "My relative goes shopping, lunch out and on lots of trips out".

Care plans lacked enough person specific detail which meant people may be at risk of receiving inappropriate support from staff who may not know them well. The provider said the staff supporting people was consistent but sometimes staff who worked at the providers other service covered shifts and may not be as familiar with people. Any new staff recruited could not rely on the care plans as an adequate source of information. Some documents lacked important information, for example; one person used various objects to keep their anxiety levels low. Staff had a good understanding of the persons needs although information about the importance of these objects had not been reflected in the persons care plan. A staff member described to us how they helped the person manage their behaviours when they become anxious. The staff member said, "I think this is where we have slipped up. We all know how to deal with (person) but we have not written it down".

A person's communication guidance said that they relied on staff to understand if they were in pain, were hungry or thirsty but there was no specific information to describe how staff could recognise this. Staff told us that a person could self-harm; the persons care file contained no guidance for staff to follow should the person require support to manage this although staff could describe the intervention strategies they may use. Another person had been diagnosed with depression but there was no guidance in their care file to describe how this could affect the person or how staff could support them.

The deputy manager showed us additional support plans for a person when we could not find information in the persons care plan. We asked the deputy manager why the information was not kept on the person's current care file which staff had access to. They said that the previous registered manager had always kept it elsewhere so they did not want to move it. This demonstrated a lack of understanding about the importance of keeping relevant information available for staff to refer to support people with their needs.

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

People's care files included a pen picture, risk assessments, a complaints policy, health information, likes and dislikes, communication information and preferences around bedtime, and personal care routines. Although parts of the care plans needed to be updated to reflect people's current needs, existing staff had a good understanding of how to support people in their preferred way. One person had an IPad to help them communicate, a relative said, "(Relative) has an IPad, I know the staff have been using it with them because when I visit new pictures have appeared on it. My biggest fear when my relative moved in here was that the service would not be adaptable to their needs but they have been very adaptable".

People were offered a variety of activities to do inside and outside of the service, and were included in deciding what interests they wished to pursue. A staff member said, "People do quite a lot, the other week they went out for dinner and recently went to a show and a 60`s night. We have a Christmas party coming up where there will be games and music". During the inspection people went out to do activities, one person went to a sensory session, and another person went to the gym. Staff said that another person usually attended a day centre three days a week but had not been well recently so was not going this week. Other activities people participated in were going to the rare breeds centre, and doing the weekly shopping. When people were in the service staff offered them various activities and objects to keep them interested. A staff member asked people if they wanted to join in an arts and crafts session. During this activity people and staff communicated with each other throughout and staff members were patient and praised people's efforts. People had recently visited the reindeer centre and all people had been on holidays during the year to the New Forest and Norfolk.

People had access to an easy read complaints policy in their care files. The easy read complaints policy gave people information about who they could talk to, what happened if people were dissatisfied with the response the provider gave, and who else could help the person with their complaint. Some people would find it difficult to understand how to complain following the formal process. They relied on staff to recognise if they were unhappy about the service they were receiving by understanding their body language and other means of communicating. A relative told us they understood who they could make complaints to and were confident the provider would respond if they were unhappy. They said, "I've always found staff very approachable, we sit and talk openly. The staff are not defensive and I truly believe they want the best for my relative". The service did not have any unresolved complaints and had received one compliment.

Inadequate

# Is the service well-led?

## Our findings

A staff member said, "The management is generally approachable but I don't know about confidentiality sometimes relating to staff". A relative said that they received questionnaires to complete about the service their relative received and had been invited to reviews regarding their relatives care and support.

The provider lacked oversight of the service. The service was run as a small family home and the provider told us much of the communication between the staff team was verbal. The provider and the two deputy managers were completing their level five diplomas in health and social care which is the recognised qualification for managing a residential service. The deputy managers worked between the providers two services but were usually based at one service for continuity. The provider and deputy managers said that they were in the process of learning their roles and responsibilities in regards to managing the service since the partnership changed in May 2016. However, the provider was previously a co-owner of the service and registered manager so understanding of their role and responsibilities should have been well embedded when the registration changed. The provider lacked understanding regarding the importance of maintaining accurate, complete and contemporaneous records in respect of the service delivery which impacted on the care and support people received. The provider lacked understanding of their responsibilities when recruiting staff. The provider had not ensured staff had enough information to support people's needs well. The provider relied on the skills and knowledge of staff to provide safe care and treatment to people but did not have an effective system to ensure staff were achieving this.

The providers systems for monitoring staff performance were poor. We showed the provider a number of incident reports which used language which did not demonstrate respect towards people's complex needs. The provider said they were unaware of these incidents but had spoken to the staff member previously about the way they wrote reports. Recordings of the conversations the provider had with the staff member were unavailable.

Although the provider had a quality assurance policy, it had not been updated for a substantial amount of time and made reference to information which was out of date. For example the policy referred to the Commissions predecessors' name. The policy did not robustly set out how the service was going to monitor its service delivery or drive improvement when areas of improvement were identified.

The provider did not conduct any of their own internal quality assurance audits and did not competency check staff to assess continuous quality of care. Effective systems were not in place to assess and monitor the quality of care. For example, the provider had not audited care plans or PEEPS and medicine errors had not been audited for patterns to understand if particular staff continued to make errors. MCA and DoLS assessments were missing, training information was unavailable, supervision was infrequent and information was unavailable, and accidents and incidents had not been audited so additional measures could be implemented to reduce the likelihood or repeating incidents which could place people at risk. All of these areas were highlighted during the inspection as areas that needed to improve. The provider said, "We don't do any audits apart form a yearly quality assurance check. I agree we could do more audits for oversight". We were not shown any recorded information about how the provider used their annual quality

assurance check to make improvement in the service.

Formal house meetings for people and staff were not held at the service which meant opportunities for formal reviews of the service were not discussed or recorded. A staff member told us they had not had staff meetings or been given questionnaires to complete and they felt this was because the provider did not want to hear any negative comments about the service. The provider said it was too difficult to arrange staff meetings because there was no suitable time in the week to do it and staff who worked wake nights would have to come in during the day. The last recorded meeting had been in 2013, the provider said that one meeting in 2016 had been held before the previous registered manager had left in May but minutes of this meeting were not available.

The provider said that relatives were issued with questionnaires to complete to obtain feedback about the quality of the care provision. The questionnaires asked questions such as; 'are you kept fully informed of any changes etc. with your relative', 'are you happy with the care your relative receives' and 'do you feel your relative lives in comfortable surroundings'. The provider said, "When we get quality assurance questionnaires we put the feedback on the board for staff to read". The provider did not do anything else with this information or produce action plans to drive improvement in the service.

The registered person had failed to identify the shortfalls at the service through regular effective auditing. The provider had not maintained accurate, complete and contemporaneous records or used feedback to drive improvement in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to report a previous safeguarding incident to the local authority for further investigation and had not notified CQC which is a requirement. There had been a recent incident which had been reported to the local authority although the provider had failed to notify CQC.

The provider had failed to notify the Commission of safeguarding incidents. This is a breach of regulation 18 of the Health & Social Care Act 2008 (Registration) Regulations 2009.

The provider had clear aims and values of the service which were to strive for a family home setting, to provide people with a healthy, balanced diet taking account of likes and dislikes. For people to receive visits from family and friends. To give people opportunities for a wide and varied social life and for people to be respected by staff and other people.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify the Commission of safeguarding incidents. Regulation 18(2)(e). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. Regulation 9(1)(3)(a)(b)(c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered person had not acted in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to have robust management of medicines.<br>The provider had not done everything reasonably practical to mitigate the risk of harm to people. The provider had not ensured the premises was safe for people to use and had not provided appropriate equipment. |

Regulation 12(2)(a)(b)(d)(g).

| 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<br><br>The provider had failed to have proper systems and processes in place to protect people from abuse and improper treatment. Regulation 13(1)(2)(3). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered person had failed to identify the shortfalls at the service through regular effective auditing. The provider had not maintained accurate, complete and contemporaneous records or used feedback to drive improvement in the service. Regulation 17(1)(2)(a)(b)(c)(e). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>There was a lack of effective and safe recruitment processes. Regulation 19(1)(2)(3)(a)(b)(c). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received appropriate training and support to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a). |