Mr Stephen Antony Campbell

The Beaches

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 12 July 2017 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. 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 although one person's mobility meant they could not access this alone. 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 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. The provider was not present throughout the inspection; the service had a newly appointed deputy manager who was present throughout the inspection.

The service was last inspected in December 2016 where eight breaches of our regulations were identified. The well led domain was rated as inadequate and an overall rating of requires improvement was given at that inspection. The breaches of regulation related to notification of incidents, person centred care, obtaining consent, management of medicines, risk assessment, safeguarding, staff employed, staff training, and leadership and management.

The provider was required to submit an action plan to The Commission following the inspection in December 2016 to outline how they proposed to improve the service and meet the breaches. The provider failed to submit their action plan by the required date and was asked three times by the Commission before this was received. The provider told us that they had made improvements to all areas on the service which had been identified as a concern. At this inspection we found that little action had been taken to address the concerns raised previously. The provider continued to be in breach of the regulations identified at the previous inspection.

Recordings of accidents and incidents were not consistent, the provider lacked oversight of incident management. Risk assessments had not been implemented 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. The provider's processes for recording and responding to safeguarding incidents were not robust.

The processes for auditing medicine and making improvements when errors were made were not robust. Recommendations made by a healthcare professional about the management of medicines had not been fully responded to. This meant people were at risk of receiving medicines in an unsafe way.

Staff had not been effectively trained, supported or monitored to ensure they were able to support people well with their individual needs. Induction processes did not adequately prepare new staff to complete their roles.

Risk to people's health and wellbeing had not been assessed or monitored well.

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. Certain restrictions had been placed on people in regards to simple everyday decisions, and capacity had not been assessed or a best interest process followed.

People did not benefit from care plans which reflected their preferences and individual needs. New staff relied on other staff to guide their practice. Staff did not have any guidance to refer to when supporting people's behaviour.

The provider lacked oversight and improvement was not driven. The provider had not kept accurate or complete records to support staff to deliver safe care and treatment to people. 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 had not conducted any internal quality assurance or audits of the service.

There were suitable numbers of staff on shift to meet people's needs, staff responded to people in a kind and caring way. When people required reassurances staff were patient in their approach. People were treated with dignity and respect and staff interacted with people in an interested and compassionate way.

Appropriate safety checks were made in relation to the environment to keep people safe.

People had choice around their food and drinks and staff encouraged them to make their own decisions and choices. People were supported to attend activities and day trips outside of the service and were offered various activities within the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not implemented to reduce risks to people when potential harm was identified.

Safeguarding incidents had not always been reported.

Incident and accidents were not robustly monitored by the provider.

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

There were enough staff to support people.

Is the service effective?

Inadequate

The service was not effective.

People's rights had not consistently been protected by proper use of the Mental Capacity Act (MCA) 2005.

Staff had not received the specific training they required to support people with particular needs. Not all staff had received supervision to support and guide their practice.

People's health had not always been monitored or responded to well.

People had choice around their food and drinks.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had not ensured staff had effective guidance in place to refer to when supporting people with their needs which impacted on the care delivery.

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.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people did not benefit from care plans to identify their specific needs. Other people's care plans were partially completed with conflicting information.

There were no behavioural guidelines 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 provider lacked oversight and improvement was not driven. Concerns raised during the last inspection had not been addressed.

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.

Feedback was not sought so improvements to the service could be made.

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 12 July 2017 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. 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 two people, one healthcare professional, two staff, and the deputy manager. Before the inspection we received feedback from 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, 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.

Inadequate

Is the service safe?

Our findings

At our last inspection in December 2016 we found that the provider did not have a robust process in place for reporting incidents and protecting people from harm which was a breach of Regulation 13 of the Health and Social Care Act 2008. Although the provider had made minor improvements and had updated their safeguarding policy this continued to be an area of concern.

The provider had not always taken appropriate action to deal with incidents where people had been at risk of abuse. An incident which had happened in June 2017 stated, '(Person) has constantly picked on a fellow peer. This is becoming a regular behaviour, the home manger has been informed, he will be making the care manager aware'. We asked the deputy manager what had happened as a result of this and was told that the manager had not contacted the care manager so the incident had been left unreported.

There was no formal monitoring system in place to identify patterns or trends in regards to incidents. There were no supporting guidance to outline the behaviours people could display and how staff could respond and support people in the most appropriate and consistent way. One staff member said, "(Persons) behaviour, I ignore it, that's not what I've been told but that's what I do as I find this works well and the person calms down sooner". Not all staff had received any formal training in protecting people from harm. New staff members had not been given information about how they should report incidents of concern following the providers own process. Staff showed a basic awareness of different forms of abuse.

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

At our last inspection the provider was not properly assessing or mitigating risks to people's health and safety. There were ineffective reporting and recording of accidents and incidents which was a breach of Regulation 12 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

Risk to people's health and wellbeing had not been assessed or monitored well. Not all accidents or incidents had been recorded. We were told by a healthcare professional that one person had previously had a choking incident. There were no records of this incident and a choking risk assessment had not been implemented. A referral had been made to the speech and language therapist following observations made by another health care professional who had concerns with how the person drank. We asked the deputy manager why the incident had not been recorded and they told us, "An incident wasn't recorded for the choking incident as the incident folder wasn't in place then".

People did not have risk assessments in place to identify areas of potential harm or outline the interventions used to minimise risk to people's health. Two people were at risk of choking and falls and neither had risk assessments in situ to support or guide staff practice. One person's mobility had significantly decreased and they often fell. During the inspection they were prevented from going out into the garden because of

concerns they may fall from the step. We asked a member staff what specific risk assessment they followed to minimise the risk to the person falling they said, "(Person) is very unstable, we just stand and guide and move objects".

The provider had not done everything reasonably practical to mitigate the risk of harm to people. This is a continued breach of regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to have robust management of medicines which was a breach of Regulation 12 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

The provider's processes for auditing medicine were not robust. The provider did not complete any audits on medicines apart from a daily count to ensure medicines were not missing. This meant it was not possible to see how the provider learnt from errors or improved practice. There were no records of staff being regularly competency checked even after mistakes were made. An incident had been recorded in June 2017 which stated '(Staff) suspended form administering medication immediately for two days and until they have been observed administering medication'. There were no records that this observation had been completed although the staff member was administering medicines to people. The deputy manager said they observed staff but had not made any records of this.

An audit had been conducted by the pharmacy which supplied medicines to the people living at the service in March 2017. They had made several recommendations which they had recorded as 'Urgent action needed'. This included ensuring a particular medicine was administered 30 to 60 minutes before breakfast, cod liver oil capsules being labelled with the person's name who received them, competency checks being carried out with staff at least annually and to implement guidance for an epilepsy medicine. The provider had not taken enough action to meet the pharmacist recommendations.

The deputy manager told us the particular medicine which should be given 30 to 60 minutes before breakfast was administered in this way but the MAR record only stated it should be given before breakfast and did not specify the required timescale. This meant the provider could not be sure staff administered the medicine in the correct way. Guidelines for administering the epilepsy medicine had been implemented but did not give enough information to instruct staff well. The document said, 'If (Person) has a seizure give one 5mg Epistatus pre-filled syringe of Buccal solution immediately and dial 999. A further 5mg can by repeated after 10 minutes if required'. There was no further information to inform staff of the maximum dose the person should receive in a 24 hour period, how they should support the person before or after administration or what signs and symptoms they should be aware of. There were no further guidelines around the management of the person's epilepsy in their care file.

Some people were prescribed occasional medicines (PRN) and were unable to verbally request their medicines so relied on staff to understand their body language should they require it. Two PRN medication protocols had been partially completed for one person. The protocols did not contain information about the minimum or maximum dosage, what signs and symptoms to observe, any possible interaction between other medicines or how to recognise when the person required this medicine.

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.

At our last inspection the provider had failed to have effective and safe recruitment processes which was a

breach of Regulation 19 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

The provider had completed most checks to ensure that staff were suitable for their roles. Checks included employment history including exploration into any gaps, reference checks and health checks. However, one staff members Disclosure and Barring Service (DBS) check had been completed by their previous employer and was over a year old. The staff member said they had a portable DBS and had given the provider the details of their discloser which they could check online to ensure it remained clear but the provider had failed to make any records of completing this check. DBS checks identified if prospective staff had a criminal record or were barred from working with adults. Two other staff had disclosure checks; however, these were only 'basic' checks which meant that information to see if the staff member had been previously barred from working with adults or had any spent convictions had not been checked. One staff members original identification had not been viewed by the provider, a copy of the identification had been signed as seen by their previous employer.

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

At the previous inspection 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. 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. At this inspection although peoples bedrooms doors were not propped open, safety devices had still not been fitted to doors. We were assured that people never propped their doors open although next to one person's door was a door wedge. We recommend the provider takes the appropriate action to ensure the risk to people's safety in the event of a fire is reduced.

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. The deputy manager had updated PEEPS which contained enough information to inform staff how people should be supported in the event of a fire. Although fire drills were being conducted records did not contain details about how long evacuations took or who was involved which meant the provider could not be assured all staff were familiar with the evacuation process or if processes were successfully completed in the minimal amount of time. This is an area that requires improvement.

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 one wake night staff were deployed. 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. 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.

Inadequate

Is the service effective?

Our findings

At our last inspection the provider had not ensured staff received the right support and appropriate training to enable them to carry out their duties which was a breach of Regulation 18 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

Staff had not been effectively trained, supported or monitored to ensure they were able to support people well with their individual needs. Induction processes did not adequately prepare new staff to complete their roles. A new staff member had commenced work two days previously. Although they had worked in the care sector before they had not been offered any period of time to shadow other staff and had been allocated immediately onto the rota as a full staff member. They had administered medicines and supported people with their personal care but records of any competency checks had not been recorded. The deputy manager said they were going to start the staff member's induction on the day of our inspection although they had already been supporting people with all aspects of their care. 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, "I'm not sure if we're going to do The Care Certificate yet, not sure what's happening".

An induction booklet was issued to new staff to complete that contained basic information about policies and procedures and general information about the service. The new staff member could not refer to care plans as information was incomplete or conflicting so relied on other staff to guide their practice. They said, "The care plans need work, I go by what the other staff tell me. Training, haven't had any here yet, have transferred some of my other training (from previous employment), haven't had any competency checks, I administer medicines. I'm trying to soak all the information in about people's behaviour, there's no guidance about how to manage (persons) behaviour".

The provider told us at the previous inspection that formal supervisions were an area that needed to improve. 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. Supervision had not improved and only two staff had received any formal supervision this year.

A training matrix was available to view the current qualifications staff had achieved. Not all staff had received the required training to support people with their individual needs such as managing epilepsy, fire safety, mental capacity awareness, and autism. During the inspection two people were supported by two staff whilst out shopping who had not received all of their mandatory training. There was potential risk that people would not be supported well with their specific needs such as managing their epilepsy. Staff had not recognised the change in a person's ability to drink their drinks safely. A healthcare professional said, "There may be a need for staff to have swallow training as they hadn't picked up on this".

Staff had not received appropriate training and support to enable them to carry out the duties they are employed to perform. This was a continued breach of regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

At our last inspection the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

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 provider 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. We asked a staff member why certain restrictive equipment had been implemented around the service to restrict people from entering certain rooms and they did not know. The deputy manager said one person currently had a DoLS in place. However, this had only been authorised for seven days and had expired in January 2017 and no further applications had been made although the person continued to be restricted. Another person had also been restricted in their movement around the service but a capacity assessment or DoLS application had not been considered. A document called 'Guidelines for Stairgate' said, 'A stairgate has been fitted at the bottom of the stairs to protect all service users from entering bedrooms and protecting their belongings'. Two people were able to independently open the stairgate but two others had to be accompanied by staff at all times when they wanted to go to their bedrooms.

Certain restrictions had been placed on people in regards to simple everyday decisions, and capacity had not been assessed or a best interest process followed. 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. 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 a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health had not always been monitored or responded to well. One person had been assigned daily exercises to complete by the occupational therapist (OT) to improve their mobility. The occupation therapist reported on the 20 June 2017 that they were concerned with the deterioration in the person's mobility. The occupational therapist expressed further concerns on the 28 June 2017. A 'record of visit' report stated, '(OT)

still concerned about the lack of improvement in (persons) left side from the hip to the knee and back calf muscle, we are to do the exercises daily when (person) not so tired'. There were no recordings of when the person had been offered, declined or completed their exercises with staff. A description of the exercises required were not readily available for staff to view, the deputy moved the information sheet to the persons care plan during the inspection. Because of the poor recordings the provider could not be assured of the frequency that exercises were completed and were unable to feedback accurate information to the OT to support the person further.

People were involved in writing the menus and choosing their meals. People were offered alternative options if they did not want what was on the menu each day. One person was asked by the deputy manager what they would like for their lunch, the person changed their mind frequently but their requests were responded to. Other people had lunch whilst they were out running errands, people were offered drinks frequently to ensure they were well hydrated. One person required a thickener to be added to their drinks as advised by the speech and language therapist (SALT). Staff understood this was necessary and ensured the person received drinks in the correct way.

Requires Improvement

Is the service caring?

Our findings

Although staff interactions were compassionate and well-intended; knowledge levels and a lack of awareness did not always enable staff to recognise risk or respond in a meaningful way. For example, staff had not recognised the need for one person to complete exercises set by the Occupational Therapist. Staff had not questioned practice or recognised potential consequences of not supporting the person to complete their exercises or report their concerns if the person refused.

The provider had not ensured staff had effective guidance in place to refer to when supporting people with their needs and relied on the knowledge of other staff to guide practice. The provider could not be sure of the competency of staff or if the care and support people received was appropriate. Staff said the provider was very caring but did not understand the importance of keeping good records, this impacted on the care people received.

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

Not all people could freely move around their home and the provider had not assessed people's capacity or implemented risk assessments. Although the provider's intentions had been well intended they had not identified if the restrictions they had placed on people were the least restrictive option available.

There was good humour and rapport between people and staff and people appeared relaxed and happy in the service. Staff took an interest in what people told them and spent time talking to people about their day and what they planned to do. One person requested to watch a DVD a staff member frequently asked the person if they were enjoying it. The staff member said, "Oh look a scary bit!" and the person acted out part of the scene. When the person sought reassurance about what they were going to do that afternoon staff responded immediately. The person frequently asked when other staff would return to the service. The staff member spoke patiently and repeated reassurance as many times as the person needed it. Staff demonstrated kindness and care in their approach to people.

Staff understood the importance of maintaining people's dignity. One person came into the lounge and had removed some of their clothing. Staff quickly responded to the person and supported them to find some other suitable clothing to maintain their dignity.

People's privacy was respected; staff asked for people's permission before showing us their bedrooms. One person said they did not want us to view their bedroom, their wishes were respected and the staff member did not try to persuade them to change their mind. 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.

Staff demonstrated caring attitudes towards people. For example, one person was unsteady on their feet so staff were extra vigilant to ensure they were close by when the person moved around the service. They

reminded the person to walk slowly and asked them if they were okay. People had access to advocacy service if they needed this. (An advocate is a person who helps other people make their needs and wishes known).

Staff tried to engage with people who found communication difficult and offered different stimulation to promote their well-being. A staff member said, "I tried to engage (person) with an activity yesterday but they kept walking away. (Person) likes their feet rubbed and physical contact. I got their tent out yesterday so we could put all the coloured sensory balls in it".

Requires Improvement

Is the service responsive?

Our findings

The deputy manager said, "I don't know why all the care plans were taken out before they were updated, I know we should have them in place. New staff shouldn't just rely on other staff to tell them how to support people, otherwise care plans wouldn't be needed at all".

At our last inspection the provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met which was a breach of Regulation 9 of the Health and Social Care Act 2008. This continued to be an area of concern at this inspection.

All care plans had been archived in large boxes, most information contained in people's files were either incomplete or not completed at all. There was limited information about how to support people with individual needs such as personal care or information about managing risk. We asked the deputy manager to locate specific guidance around people's individual needs such as how to manage epilepsy, behaviour and falls. The deputy manager was unable to locate up to date guidance easily. The information they showed us was out of date, and contradictory.

For example, in one person's care file there was a recording about reviewing their diabetes. The deputy manager said there had been some confusion with other health care professionals and the person did not have diabetes. The person's care plan did not make this clear. A new staff member had commenced working at the service at the start of the week, they told us they relied on other staff to tell them how to respond and manage people's needs as they had no documentation to refer to. Any new staff recruited could not rely on the care plans as an adequate source of information and many documents within the care plans were incomplete or completely blank.

One person could self-harm; the persons care file contained no guidance for staff to follow should the person require support to manage this. 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, associated behaviour guidance to support the person with verbal or physical outburst had not been implemented.

During the inspection one person was attempting to go out to the garden and appeared anxious. The staff member explained the person did not like certain objects out of place as this could make them anxious. The staff member returned the objects to the place the person preferred. There was no information in the persons care plan about this, had a staff member unfamiliar with the person been supporting them they may not have been able to alleviate their anxieties.

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

People had access to an easy read complaints policy displayed on the notice board. 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. No formal complaints had been made since the previous inspection. The deputy manager said, "I would automatically fill in a form is someone said they had a complaint. Wouldn't be able to know with (person) except if you looked at body language". There was some information on this person's communication passport which described how the person may act if angry or sad but more information was required in the persons care plan to ensure newer staff could understand their behaviour fully. This is an area that requires improvement.

During the inspection one person had gone out for the day with their relative, two people had gone out shopping and for lunch and another person had stayed at home waiting for a visit from a healthcare professional. People had recently been on a holiday to Norfolk for a week and another holiday to the Lake District was being arranged for October 2017. Activities were reviewed to establish if they were still suitable and enjoyed by people. One person went to the Rare Breeds Centre each week to do crafts, and another person was planning on starting swimming. During the inspection a staff member sat with a person looking through their iPad and found 80s music they enjoyed while the person interacted with sensory equipment that they enjoyed to touch and feel.

Inadequate

Is the service well-led?

Our findings

A staff member said, "The provider does really care about people but doesn't do paperwork and doesn't understand it. They focus on care for people like making sure they get their activities but doesn't care how paperwork needs to reflect this".

At our last inspection the provider had failed to identify the shortfalls at the service through regular effective auditing which was a breach of Regulation 17 of the Health and Social Care Act 2008. This continued to be an area of concern.

The provider continued to lack oversight of the service and had not taken action to meet the breaches found during the previous inspection. 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 accidents or incidents so additional measures could be implemented to reduce the likelihood or repeating incidents which could place people at risk, they had not ensured staff had sufficient documentation to refer to when supporting people with their needs, risk assessment had not been implemented to minimise the likelihood of harm people could be exposed to, MCA and DoLS assessments were missing and people had been unlawfully restricted.

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 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. We were not shown any recorded information about how the provider sought feedback from individuals to improve the service delivery. They had not distributed questionnaires or quality assurance information to analyse so action plans could be implemented to respond to suggestions.

The provider 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 continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

At our last inspection the provider had failed to notify the Commission of safeguarding incidents which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. This continued to be an area of concern.

The provider had failed to report a safeguarding incident to the local authority for further investigation and had not notified CQC which is a requirement. There had been two additional safeguarding incidents in March 2017 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 deputy manager had implemented an audit folder so they could check specific areas of the service to identify areas that required improvement and action. They told us they had not had time to start checks yet as they had been updating policies and procedures as well as covering shifts. They told us they had started to update peoples care plans but had not been able to complete them due to limited time they had in the office. They said the time they could spend in the office would improve as a new staff member had been recruited. The deputy manager said, "A lot has been done, it probably won't look like a lot to you but I've been doing lots of work at home with policies and procedures, updating them. It's not where you would want it to be but I hope you can see the changes".

Previously formal meetings for staff had not been held at the service which meant formal review of the service were not discussed or recorded. The provider had improved this and held staff meetings in March and June 2017. During the meetings staff were given information about the service and offered the opportunity to feedback what was going well or what could improve. For example, during the meeting in March 2017 staff fedback that they felt the monthly disco people attended was no longer suitable. The provider said they would discuss this with people to identify what their views were but we did not see any evidence that this had happened.