National Autistic Society (The)

# Mendip House

## Inspection report

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12 May 2016
14 June 2016
15 June 2016
17 June 2016

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

Mendip House is a large detached bungalow situated in the extensive grounds of Somerset Court. The home accommodates six people who have autism and complex support needs. Five people live in the main part of the home; one person lives in a self-contained annexe. People living at Mendip House can access all other facilities on the Somerset Court site which include various day services.

A registered manager was responsible for the service, although they were not currently working at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We received serious concerns in relation to this service in May 2016. As a result we inspected urgently on 12 May 2016. This was unannounced and carried out by two inspectors. Following this inspection visit we liaised with the provider, the police and the local authority safeguarding team. We then carried out further unannounced inspection visits on 14, 15 and 17 June 2016. These were also carried out by two inspectors.

People had not been kept safe. A damaging culture had been allowed to develop within the staff team which had adversely affected people's lives. Staff had not ensured people's safety; this had been compromised for some time. Risks to people were not properly assessed, reviewed or managed. Staff had not reported concerns about people's welfare and safety when they had them.

Some areas of medicines management were not safe. Staff recruitment was not managed safely. Accidents and incidents were not always recorded or followed up to ensure people's safety or improve their care. Health and safety checks on the home were not carried out which put people at risk.

Current staff were kind and caring but people had not been treated with kindness and compassion previously. People appeared relaxed in the company of current staff on duty. Staff knew the people they were supporting. Staffing was adequate to ensure the continuity of people's service. Experienced staff from some of the provider's other services on the Somerset Court site were working in the home to provide cover for the staff who were not currently working. There were permanent staff on each shift.

People's health care support was poor as health care records were either missing or poorly recorded. People's health plans did not reflect their current needs. People's legal rights in relation to decision making and restrictions on their liberty were not upheld.

People did not have a choice of nutritious meals and drinks. Some people's diets were very poor placing them at risk of malnutrition.

Staff training was not put into practice; some training was out of date. Staff were not supervised regularly

and concerns raised in supervisions were not acted upon. Poor staff practice was not addressed and improved.

Some people did not have any formal system to communicate their wishes or feelings. People were therefore unable, and had not been supported to express their views about life in the home. Staff had not raised concerns or complaints on people's behalf despite the culture prevalent within the home adversely affecting them. Concerns and complaints had not been listened to or responded to. Staff reported a failure to act on concerns they raised which led to them not reporting them any longer.

People did not receive personalised care which was responsive to their needs. Care planning was confusing and out of date. Plans were not reviewed and did not reflect people's current needs. Some records could not be located during the inspection; there was evidence these records had never been completed.

The home had been extremely poorly managed. There had been a chaotic approach to management systems, structures and record keeping. The provider's governance and auditing of the service had been weak and ineffective. There had been a lack of action when the home failed to improve in identified areas. The damaging staff culture was known about and discussed both within the home and by the senior management team but appropriate action was not taken.

There had been a failure to operate the home in an open and transparent way or in accordance with the law. Significant events which adversely affected people's safety and welfare had not been reported to either the CQC of other authorities such as the police or the local authority safeguarding team. This had severely compromised people's welfare and safety.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of The Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People were not protected from abuse. Risks were not assessed, reviewed or managed well.

The provider had failed to ensure people's safety. Staff recruitment was not managed in a safe way.

People were not supported with their medicines in a consistently safe way. The environment was unsafe in some areas.

### Is the service effective?

**Inadequate**

The service was not effective.

Staffing was adequate to ensure the continuity of people's service.

People's health plans did not reflect their current needs. The provider had failed to ensure people received the care and treatment they needed.

People's legal rights in relation to decision making and restrictions on their liberty were not upheld. People did not have a choice of nutritious meals and drinks.

Staff did not receive on-going training or support to make sure they had the skills and knowledge to provide effective care to people.

### Is the service caring?

**Inadequate**

The service was not caring.

People had not been treated with kindness and patience, or with dignity nor had their privacy respected.

People were not always supported to keep in touch with their friends and relations.

People, and those close to them, were not involved in decisions

about the running of the home as well as people's care.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People did not choose a lifestyle which suited them. They did not use community facilities and were not supported to follow their personal interests.

The provider had not ensured people, and those close to them, were involved in planning and reviewing care. People did not receive care and support which was responsive to their changing needs.

The provider had not ensured people, and those close to them, shared their views on the care people received and on the home more generally. People's views were not used by the provider to develop or improve the service.

## Is the service well-led?

**Inadequate**

The service was not well-led. Management was weak and ineffective. There was a lack of accountability and responsibility within the management team and senior leadership team.

The aims of the service were well defined but not put into practice.

The provider did not work in partnership with other professionals to make sure people received the care and support which met their needs. People were not part of their local community.

The provider's quality assurance systems were ineffective. They failed to ensure people were protected from poor care and any areas for improvement were identified and addressed.

The provider had failed to operate the service in an open and transparent way. Significant events which had occurred had not been reported to relevant agencies.

# Mendip 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.

We received serious concerns in relation to this service in May 2016. As a result we inspected urgently on 12 May 2016. This was unannounced and carried out by two inspectors. Following this inspection visit we liaised with the provider, the police and the local authority safeguarding team. We then carried out further unannounced inspection visits on 14, 15 and 17 June 2016. These were also carried out by two inspectors. During our inspection we spoke with eight members of staff, the acting manager, the provider's area manager and the human resources manager. We met each person who lived at the home and observed staff interacting and supporting people in communal areas.

Following our visits to the home we spoke with local service operations manager (who oversee the provider's homes) on 29 June 2016 as they were on leave when we visited the home earlier in June. We spoke with four relatives and with staff from the local authorities who pay for people to live at the home between 4 and 8 July 2016. We continue to meet and liaise with the police and the local authority safeguarding team.

Before our inspection we reviewed all of the information we held about the home. We reviewed information we had received from the provider and other agencies, such as the police and the local authority safeguarding team. We looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to send us by law.

Inadequate

# Is the service safe?

## Our findings

The service was not safe. During our inspection we found people were vulnerable because they had communication difficulties associated with their autism. They were not protected from abuse. People were not able to say if they felt safe. Two people had no formal communication system. People had used systems before but staff had stopped using them. It was unclear why. There were no records in people's care plans of any indicators staff should be aware of which may have shown people were being abused or mistreated. One relative said "[Name] wouldn't be able to tell you if anything was wrong. [Name's] very vulnerable."

Serious concerns in relation to people's welfare and safety had been raised by staff using the whistleblowing procedure in May 2016. A number of serious allegations, such as abuse, neglect and degrading treatment of people, were made. One staff member raised their concerns with us directly as they had no confidence the provider would take their concerns seriously and act on them. The provider reported these concerns to the police and the local authority safeguarding team immediately whose investigations continue.

The provider intended to carry out their own investigation into the allegations raised in May 2016. The provider then commissioned this type of investigation. The provider has confirmed to us their investigation's findings were "On the balance of probability" people had been subjected to abusive and degrading treatment. The provider also confirmed a damaging culture had developed in the staff team which had led to this happening.

Staff spoken with and records seen showed a culture had developed in the staff team which severely compromised people's safety. Records seen showed a cultural issue in the staff team was first recorded in 2014. Staff had not always reported concerns about people's safety. When concerns had been raised staff did not feel any action had been taken. Staff said they had raised concerns either verbally or during supervision sessions. Some supervision notes showed staff had raised concerns and there were no records of any action being taken. There were also no records of the concerns reported verbally outside of supervisions, which meant these concerns had not been taken seriously or acted upon. One staff member said they had raised concerns "But nothing was done." They "Did not raise further concerns; nothing would be done." The provider told us the registered manager "Should have been far more proactive" in the management of the home.

Staff were asked to sign a declaration each time they had a formal supervision session to confirm they had not witnessed any abuse. Staff had routinely signed to say they had not but had later reported alleged abuse to the provider as part of their investigation. Some staff were worried about reporting incidents when they occurred as they had not felt safe to do so. One staff member said they "Didn't report any concerns." They felt "Intimidated and scared." The provider has confirmed to us their investigation findings were there was "A culture where individuals are scared to come forward and complain if they have concerns since they fear retaliation."

During the inspection evidence was uncovered by the local authority investigations team which showed people's money was being misused by staff. When people went out for a meal they paid for not only their

own meal but also paid for the staff member's meal as well. This had happened to each person who lived at the home since 2014. This misuse of people's money was financial abuse. The provider stated they will reimburse each person once they have established how much they are owed.

Staff had not received up to date training in safeguarding adults from the risk of abuse. Staff training records showed staff needed to complete annual on line training. Thirteen members of staff's training were out of date; seven staff had not completed this training since 2012. The acting manager, who had been in post for five weeks, told us they had now arranged 'face to face' training for all staff.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone who lived at the home required staff to manage and administer their medicines. The procedures for the administration of medicines could place people at risk. Medicines were supplied by the pharmacy in sealed monitored dosage packages which provided details of the prescribed medicine, the name of the person it was for and the time the medicine should be taken. The acting manager explained how medicines were administered to people who lived at the home. They told us they removed the tablets from the sealed package and transferred the tablets to a medicine pot. They then carried the pot through the home to wherever the person was. We discussed the potential risks relating to this practice. The pots were not labelled with the person's name so there was a risk of the medicine being given to the wrong person. Given the very complex needs and behaviours of the people who lived at the home, there was also the risk of the member of staff administering the medicines becoming distracted and having no safe or secure place to store the medicines which could be picked up by another person using the service.

Each person had a pre-printed medicine administration record (MAR) which detailed their prescribed medicines and when they should be taken. We found three hand written entries on the MAR charts. There were no staff signatures to confirm the entries were correct and there was no information about who prescribed the medicines, when they were prescribed and what they were prescribed for. The amount received had not been recorded which meant there was no clear audit trail of what medicines were in the home.

People were not fully protected from the risk of receiving unsafe care and treatment. There were no records to demonstrate people's prescribed medicines had been regularly reviewed to ensure they remained appropriate and effective. For example, in one person's health action plan there was a letter dated 11/01/2014 which showed their medicines had been reviewed by their GP. There were no records to show the person had been reviewed since then. Each person had a 'medication review form' which stated 'to be reviewed six monthly.' None had been completed. One person's medicines records were last reviewed in 2012. The dose of medicines they needed to manage a particular health condition were contradictory. Their care plan stated the person required 150mg of the medicine twice a day whereas the MAR chart showed the dose as 175mg twice a day.

There was a failure to protect people from the risks of an unsafe environment. On the first day of our inspection we checked the temperature of the bath hot water outlets. The hot water temperature in bathrooms was above the safe limit recommended by The Health and Safety Executive (HSE) and would pose a significant scalding risk. We brought this to the attention of the acting manager at the time and they took immediate action to ensure this was addressed. Whilst this is positive, the failings had placed people at significant risk over a period of time. The registered manager and the provider had failed to ensure the health and safety of the people who lived at the home. Regular checks on hot water outlets had not been carried out since January 2016. Available records showed weekly checks on the home's fire detection and

alarm systems had not taken place since October 2015 and staff had not received fire safety training since December 2013.

Risks to people who lived at the home were not always assessed and there were no effective plans in place to manage or review identified risks. One relative said "When [name] went on holiday no risk assessments were done as far as we know. Even if they were the staff who went told us they had never seen them." One person was at risk as they had a history of leaving the home without staff support. This was first recorded as a significant risk in 2014. Staff had responded to this risk by "Using saucepans as a makeshift alarm for the backdoor to hear if it was opened." There was no record why this system had been used or why staff had not considered any safer options. The 'saucepan alarm' failed. The person had left the home on two separate occasions without staff knowing and was found walking alone on the main road towards the next village placing them self at significant risk. Another person would eat non food items. There was no specific risk assessment to help staff manage this risk. One staff member said "You just have to be quick." We read this person had eaten a cleaning cloth in June 2016 placing them self at significant risk. We saw there were non food items within their reach during our inspection.

There was no effective tool in use to pick up changes or patterns in people's behaviour which may have caused staff concern. This system was important as people would often communicate through their behaviour so this would be a key tool in identifying concerns. A staff member said "There's no system to pick up subtle changes in people's behaviour. This is what we would need to look for as often this is where you may be concerned." Accidents and incident recording and analysis were poor. Reports were not always completed for each event; some records which staff confirmed as having been completed (such as unexplained bruising for one person) had subsequently gone missing. When incidents had been recorded, such as one person eating non food items, there was no review of each incident, review of the risks to people or review of their care.

Accidents and incident reports had not always been checked. The provider's policy stated each paper copy of a report should have been checked by the registered manager and then entered on the provider's electronic reporting system. Paper copies of these reports had not been kept as they should have been in line with the provider's policy. Therefore, there was no way to check if each incident had been reviewed or if every incident had been recorded on the provider's electronic reporting system.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The procedures for staff recruitment did not protect people from the risk of abuse. Gaps in one applicant's employment history had not been explored. Where one applicant had declared unspent convictions, there were no records to show this had been discussed or their suitability to work with vulnerable people had been checked. A new DBS disclosure had not been applied for; one had been accepted from the previous employer as this was less than three months old. This was in line with the provider's policy.

One staff member's file only contained one reference. This was a character reference so there was no information about the staff member's conduct during their previous employment. In another file we found both references were dated after the staff member had started working at the home. The acting manager provided us with a staff file which contained no recruitment information at all. We asked if the recruitment documentation could be somewhere else. The acting manager confirmed there was no further information relating to this member of staff's suitability, competence, skills or character.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

It was impossible to determine if the staffing levels planned for people (such as one to one or two to one support) were provided. Most staff who worked at the home did not 'sign in and out' as they were expected to at the start and end of their shift. This had become part of the culture of the home. Some staff told us certain members of the staff team simply came and went as they pleased. Several staff also told us certain members of the staff team were lazy and did not support people as they were supposed to. One relative told us "We saw staff not doing much, sitting around a lot. Looking at their phones, rolling fags, watching TV, just not engaging with people at all. There seemed to be a very blasé attitude towards work. We did raise this but just lots of excuses from staff."

The provider has confirmed to us the investigation findings were "There are consistent reports of various individuals regularly arriving late or leaving early. These same individuals are similarly accused of spending time playing with PlayStations or using mobile phones when they should be actively supporting the individuals who live in Mendip House" and "The system for distributing workload and determining who should be doing what on any particular shift appears to be somewhat random and potentially open to abuse." This meant people had to wait for their care needs to be met; some staff actions had placed people at risk.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

Relatives felt staff had been trained but discussed a decline in some staff member's practice. One relative said they thought training about their family member's specific condition should be core training for staff but was not.

We checked staff training files. These showed basic training such as first aid, food hygiene and health and safety had been provided. Three members of staff's first aid certificate of competency had expired. This meant they may not be able to provide emergency aid to people if they needed it. Specific training such as epilepsy, mental capacity act and the deprivation of liberty safeguards to enable staff to meet individual needs was also provided. Twelve staff member's epilepsy training was out of date so they may not be able to provide the care people needed if they had an epileptic seizure. Thirteen staff member's safeguarding, mental capacity act and deprivation of liberty training was out of date. Some training had been out of date since 2011 and 2012 despite this needing to be completed every year. This meant staff had not been provided with up to date training to ensure they provided safe and effective care to people or to ensure their legal rights were protected.

Records we looked at showed staff did not complete a thorough induction programme when they commenced employment. Three of the four staff personnel files we looked at did not contain any information about an induction programme. One file had recorded the staff member had completed their induction however there were no records available and no evidence the staff member had been deemed confident or competent to carry out their role. Another personnel file contained a basic in-house induction sheet which had been signed as completed by the inductor but not the inductee. This was dated five months after the member of staff had commenced employment.

The aims of the service stated all staff received regular formal supervision and annual appraisals to support them in their professional development. Staff spoken with and records seen showed staff were not supervised regularly. One staff member said supervision "Was sporadic at best." Records showed large gaps in supervision, sometimes a year between meetings. The registered manager had stated in their own supervision records they used supervision to address poor staff practice and the cultural issues. As these had not taken place poor staff practice and the culture had been allowed to continue.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People would not easily be able to say they felt unwell so it was important staff monitored people's health closely. People's health plans were poor. People at risk of weight gain or loss were not being weighed to help ensure they remained a healthy weight. Some health plans had nothing recorded in them since 2013 although staff told us people would have seen health professionals since then. When people attended an appointment often no record was kept including the outcome which may have included changes to people's medicines or their health care. This means there was no effective way of checking if people had regular health reviews or if their health care was appropriate or met their needs.

Epilepsy care was poor. For example, one epilepsy care plan was not dated and there were no records to demonstrate the person had received the care and treatment they required. There was no information for staff about how to support the person when they had a seizure. The plan stated the person required regular appointments with specialist health professionals and annual blood tests. There were no records to confirm this had happened. The care plan contained incorrect information about the person's prescribed medicines to those in their MAR. The protocol for the administration of an as required medicine to manage their epileptic seizures was not in their care records. Staff were also unable to locate it. This means there was no clear and up to date plan to ensure their epilepsy care was appropriate or met their needs. One relative said their family member had a particular condition diagnosed two years ago. A health professional had made recommendations about how staff should provide effective care. The relative told us "This has never happened."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements had been recently made since the acting manager had been transferred to the home, people had not been protected from the risk of poor nutrition and dehydration. One relative told us they noticed reading their family member's care records they had not been eating regularly. Staff told them they did not want to eat. The relative said "I said [name] needs to eat. You can't just let people not eat. I don't know if something may have happened to them sitting at the table and that's why they didn't want to eat there. It was very worrying but staff didn't seem to be doing anything about it. They just wrote [name] wasn't eating."

We were informed the previous seven week rolling menu had been replaced by a weekly picture board menu where people were supported to make their choices from a range of pictures. One member of staff told us this was being further developed to include puddings. We found meals were basic and did not make good use of a wide range of ingredients. On two of the days we visited, one person had requested chicken nuggets which staff had cooked for them. One person's care file had recorded they were "on a diet" to help them lose weight. When we asked staff about this, nobody was aware the person was on a diet; why or when this commenced. The person's daily records showed most days staff supported them to eat out at a fast food outlet. There records showed they had little in the way of fruit or vegetables.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People would not be able to make all decisions for themselves. We therefore looked at how the Mental Capacity Act 2005 (MCA) was being adhered to. The 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. We checked whether the service was working within the principles of the MCA and found it was not.

Where people lacked capacity to make decisions, the MCA code of practice had not been followed. This code explained how the MCA should work in practice. People's capacity to make decisions had not been assessed in any of the care records we looked at. Staff were making important decisions for people without considering people's legal rights. For example, two people had been put on a diet. No assessment had been carried out to determine if each person could consent to this. Other people involved in each person's care, such as their family members, health professionals or social workers had not been consulted to see if this

decision needed to be made in people's best interests. No advocacy arrangements were in place to help people make important decisions. Staff from the home had made this decision in isolation. This meant people's legal rights were not being protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 in care homes are called the Deprivation of Liberty Safeguards (DoLS). Thirteen staff member's training in this subject was out of date. Applications had been submitted for people where staff considered people may be deprived of their liberty which had been approved. We checked whether any conditions on authorisations to deprive people of their liberty were being met and found they had not been. Two people's authorisation had two conditions which had not been complied with. This meant people's legal rights were not being protected.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Décor and furnishings in the home were tired and did not help to promote a homely feel. One relative said "The accommodation provided in Mendip, particularly the lack of en suites and private sitting areas, is not up to scratch." A sofa and an arm chair in the lounge were worn. Paintwork was chipped and walls needed painting. There was a hole below the sink in one of the bathrooms and exposed pipework around the sink in another bathroom. Some doors were missing from cupboards in the kitchen. A wall in a quiet room had been painted with a 'superhero' type mural with very bright colours. We asked about the rationale for the mural given the possibility this could heighten people's level of anxiety. We were told this had been painted by a member of staff. One relative said "Have you seen that room? Ridiculous. [Staff name] painted that. I complained about the mural as that room was meant for [name's] quiet room. Nothing was done." The acting manager told us the room would be redecorated as one person in particular who lived in the home, needed a calm and quiet area to sit on occasions.

The quality monitoring visit carried out by the provider's nominated individual in May 2016 stated "The bathrooms were not fit for purpose. Parts of the service were dirty. The kitchen is in need of a refit and the fridges and freezer needs replacement." Some improvement work had started during the inspection. Flooring was being replaced in one person's room and new furniture had been delivered.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was able to communicate verbally; they often used similar phrases or repeated what staff had said. Other people used different methods such as objects. Staff knew people well and were often able to interpret their non-verbal communication. People's care plans contained some detail about how each person communicated. However, one person's communication plan conflicted with other areas of their care records so staff may not understand what they were communicating. Another person had previously used pictures to communicate; these were no longer used and it was not clear why. The acting manager told us this person had recently been reassessed in using this system and had scored highly in the assessment. This suggests their primary form of communicating their choices, wishes and feelings had been taken away from them and staff had not respected this person's rights to engage or not engage in communication.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

When we inspected six members of staff were not currently working at the home. Experienced staff from some of the provider's other services on the Somerset Court site were working in the home to provide staffing cover. These staff knew people who lived at the home. The acting manager had ensured permanent members of staff worked on each shift to help support the temporary staff. When agency staff were used, the acting manager tried to ensure the same members of agency staff worked in the home to ensure continuity of care. Staff were being kept informed of staffing and management changes.

Inadequate

# Is the service caring?

## Our findings

Although we observed a lot of kind and friendly interactions between people and staff, staff spoken with, discussions with other agencies and records we saw showed a damaging, uncaring culture had been allowed to develop within the staff team which had adversely affected people's lives. Some members of the staff team had not had a caring relationship with people. An internal investigation in November 2014 by one of the provider's senior managers reported there was a cultural issue within the service; staff "Can sometimes over step the mark" and were "Unprofessional and stern." Concerns about the staff culture in the home continued to be raised during 2015 in some staff supervisions, in a service update report completed by the registered manager and in their own supervision but no effective action was taken to address it either by the registered manager of members of the senior management team.

Relatives had felt staff used to be caring but described a decline in some staff member's practice and attitude over a long period of time. One relative said "I think that [name] is generally well cared for." Another relative told us "Mendip became much too blokey. It was run for the staff, not the residents." They said the home was a "Lads club" [referring negatively to a group of male staff]. Mendip was deteriorating and should have been picked up." Another relative said "It was going downhill. All the warning signs were there." One relative told us after their visit in June 2016, "The atmosphere among residents was calm and peaceful. This is an improvement from a year ago. [Name] seems much happier and relaxed, and so do the other residents of Mendip House. It's very noticeable."

The provider has confirmed to us the investigation findings identified the staff culture consisted of "Boisterous behaviours, days organised around how certain members of the staff team wish to spend their time as opposed to what is best for the people they support, rotas arranged so that the young male employees are regularly able to work together with a culture in which the people they support are not respected."

People were not always treated in a dignified way. One relative said "We have seen staff sitting around ignoring people when we have visited. We have also heard staff swearing and having conversations which weren't appropriate in front of people. We complained about all this but nothing changed." We saw staff addressed people using their name but sometimes spoke about people in front of others. One member of staff spoke about one person's weight and said they had "A beer gut" in front of us and others. Some terminology in people's care records was disrespectful; one person was described as a "Drama Queen" in their care records by staff. Staff told us most staff used their mobile phones during working hours; this had become part of the staff culture despite being contrary to the provider's policy. One staff member said some staff had simply "Ignored people" whilst doing this. The provider had also subsequently confirmed to us this was happening.

Staff were not aware of and had not supported people's diverse needs. There were no cultural or spiritual needs assessed or recorded in any person's care plan. People had not been fully supported to share their views on the service they received. Some people did not have any formal way to communicate or express their views. There was no advocacy in place for any person to help them do this.

People were not encouraged to be as independent as they could be. On the days of our inspection we only saw one person use the kitchen to make themselves a drink. Although staff asked people what they would like to eat or drink, we did not observe staff supporting people to develop or maintain independent living skills. The care records we read did not contain information about people's abilities or how to support them to maintain a level of independence. One person's DoLs authorisation contained a condition which stated staff must support them to improve their daily living skills such as personal care and independent travel. This had not been acted upon.

People were not fully supported to maintain relationships with the people who were important to them, such as their friends and relations. Relatives felt there had been a decline in communication and their involvement with their family member's care. One relative said "It's all a bit hit and miss now. The newsletters had stopped. We do meet with the core team but it all feels like it's all jumbled up. Things just seem to get shelved all the time for no reason. It's a symptom of what was going on. Something should have been done about it."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

The service was not responsive. People were not protected against the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. People's care and support plans had not been regularly reviewed and did not reflect people's current needs. Also, care and support plans were bulky and contained historic information which made it difficult to locate current information. Some staff were new to the service which meant they would not have up to date or accessible information about the people they supported. This puts people at risk of inconsistent care and/or not receiving the care and support they need. One social care professional told us "Most things like care plans and communication plans are all out of date."

Each person had a care plan, health plan and behaviour plan. We found all of these to be out of date. For example one person's behaviour plan was written in 2012 and had no evidence of being reviewed since then as the behaviours described in the plan were no longer an issue for the person. Care plans described people's morning, evening and night routines although this conflicted with other parts of their care records and with how staff described their routines.

People's health plans were poor. People's time tables for activities were out of date; they did not reflect activities people currently chose. People's daily records were sparse; some had not been filled in so it was not possible to see how the person had been and how they spent their day.

People's weight records were poor. Two people had been placed on diet by staff but there was no rationale for this decision and no professionals had been involved. Neither of these two people had been weighed regularly; one person had only been weighed twice since moving to the home (in October 2014 and March 2015). It would there be impossible to determine if either person was losing or gaining weight.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one person's health file we found a 'hospital passport.' These are documents containing important information to help support people with a learning disability when they are admitted to hospital. The hospital passport had not been dated and there were no records to demonstrate this had been reviewed. Under current medication it stated "refer to MAR chart" (Medication Administration record). It also made reference to an injection the person needed every two weeks. This was not recorded on the MAR chart and there was nothing in the person's care file to tell us the person required this injection, the rationale for this or possible side effects. One member of staff told us they often supported the person to the appointments for their injection. They could not tell us why the person required the injection and they confirmed there were no records relating to the appointments attended.

In another person's care plan we saw they required a rescue medicine to be administered during certain epileptic seizures. The care plan had not been signed or dated. This prescribed medicine can only be administered by staff who had received specific training. The care plan provided one staff member's name

as the authorised person trained to administer the medicine and was dated September 2012. None of the staff we spoke with knew who the staff member was. One member of staff we spoke with told us they had not received the training to administer the medicine and they were unsure which staff had received the training. They were unsure if there was always a suitably trained member of staff on duty at all times. Staff training records showed only three staff were currently trained to administer this medicine.

Staff did not always respond appropriately to people's changing needs. A social care professional told us the person they supported "Had previously come on leaps and bounds. Very little seems to have been done by the staff team recently though." One parent said "It is a continual battle to get staff to follow professional's recommendations. Even when they do it doesn't continue." One person needed to improve their eating habits to ensure they remained healthy. Staff had stated at this person's review in October 2015 their diet had improved but this was not an accurate reflection of their daily records. These clearly showed his person mostly ate food from one particular fast food chain (often twice each day) and refused healthier alternatives.

People's participation in the planning of their care was often limited by their communication difficulties. Records showed some people attended a meeting to review their care needs. Others close to them, such as their relatives or other professionals involved in their care, were therefore consulted. There was a formal six monthly review of people's care and an annual 'person centred' review. One relative said person centred reviews were "Poorly attended, often facilitated by a person who doesn't know [their relative] where inappropriate questions are asked." Another relative told us "We now have these PCP [person centred planning] meetings. The last one was very negative about [name]. I said can we stop this? [Name] doesn't want to hear all these negative things about them." One relative said "We now rarely see anyone from the funding authority. It all changed about four years ago so no one is really looking at what's going on."

Emergency reviews for each person were currently being carried out following the serious concerns raised about people's welfare and safety in May 2016. One of these emergency reviews stated one person had initially settled well after their move to the home. However, this then stated the staff "Team had not focused on putting the right support in place for [name] so that she could improve her functioning, expand her activities and move towards identified targets." Key professionals to support this "Were not involved until recently."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and procedure. The provider's nominated individual stated each person should have a copy of the complaints policy in a format they could understand. No one within the home had one of these. People would not be able to use the provider's complaints procedure independently and so would need to rely on staff to help them or to raise concerns or complaints on their behalf. People's care records did not clearly describe what signs to look for which may show a person was unhappy, upset or being mistreated. No complaints by people in the home had been recorded despite serious concerns raised about people's welfare and safety.

One complaint made by a relative had been recorded (in 2014). Relatives spoken with said they had raised other concerns but we could not find any records of these. One relative said they "Had raised concerns on several occasions but these had not been addressed." Another relative said "I have no faith at all in the complaints process. I did make a complaint. It was basically a whitewash. We weren't shown anything we asked for that was written about our complaint."

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person confirmed they did things throughout their days that they enjoyed. Each person had good levels of staff support; they had one to one staffing at times. One person who lived at the home didn't like to leave the house. On the days we visited they enjoyed craft, music and reading sessions with staff. Other people went to day services on the Somerset Court site. Care records did not contain information about people's preferences and there were no planned activity programmes for each person. A member of staff told us "This is something that has been lacking here but we plan to introduce something."

There was a lot of unstructured time for people, particularly when they returned from day services. People were not part of their community. Record keeping was poor so it was not possible to see how often people went out. Staff told us people did go out occasionally but there were a lack of drivers in the staff team. Some people went out with or visited relatives, but this was irregular as some relatives did not live locally. We asked staff if there were opportunities for impromptu trips out. A member of staff said "If we have a driver on duty and enough staff." The records we looked at and staff spoken with showed this had been an issue for some time.

Relatives had mixed views about people's activities; some reported a steady decline in the service. One relative said of their family member "I feel they are being de-skilled, losing the skills they had." Another relative said their family member was "Involved in less activities" and there was "A disinterest from some staff."

People did have some contact with their family members. One relative said "We usually go twice a week to see [name] and take [name] out." One person had recently been on holiday abroad with their family; staff from the home had also supported them. People visited their family. Family members visited people at the home but there were mixed views about this; some relatives said communication with them had deteriorated. One relative said "They did not feel welcome in the service." When they rang the home each week they often could not get an answer. Another told us there had been a "Reduced level of activities and communication."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led. One relative said "There has been a distinct lack of leadership. I think issues should have been sent higher up. Never were though I don't think." Another relative told us "Sadly [name] turned out to be a poor manager." Staff said the home "Had lacked leadership. There was no clear direction." The management team in the home consisted of the registered manager, deputy manager and small team of senior staff. The home was overseen by the provider's senior management team, principally the provider's area manager and local service operations manager (who oversees the provider's residential services and is based at Somerset Court.)

When we inspected the registered manager was not currently working at the home; neither was the deputy manager and one member of the senior team. A manager from another of the provider's services was currently managing the home. Experienced staff from the provider's other local services had also been drafted in to cover for permanent staff who were currently not working. The Senior Leadership Team, above the Registered Manager, were aware of the poor performance of the some of the senior members of staff within the home and had taken some steps to tackle this in 2015. The provider have confirmed to us, following the serious concerns raised about people's welfare and safety, that senior staff within the home were out of their depth, "buried their head in the sand", had failed to take responsibility for the operation of the service and had not acted as appropriate role models for other staff within the home.

Staff spoken with and records reviewed showed the management within the home had been weak and ineffective for some time. There was no reliable system in place to identify when the registered manager or deputy manager worked in the home. Staff told us the registered manager had spent most of their time at the other service they managed and the deputy manager did not work their rostered hours. We found the management systems and structures to be chaotic. There was no systematic recording and filing of important records. Many records requested during the inspection could not be found; staff told us many things were not recorded even though they knew they should have been. Staff were not being supervised and there was no formal observation of staff practice. The provider had no effective system to check and improve these areas of the service.

As a result of this, and weak and ineffective organisational governance, a culture (described by staff as "Laddish" and "A gang culture") had been allowed to develop within the staff team which had adversely affected people's lives. An internal investigation in November 2014 by one of the provider's senior managers reported there was a cultural issue within the service. Their report concluded staff "Can sometimes over step the mark" and were "Unprofessional and stern." The investigation identified some staff were acting inappropriately, but action was not taken to address this.

Concerns about the culture in the home continued to be raised by staff. In April 2015 one staff member raised concerns about most staff using their mobile phones whilst working (which contravened the provider's policy) and "Inappropriate conversations" taking place between staff. In August 2015 another staff member reported they "Find the laddish behaviour [by staff] is not always appropriate.' It was noted the registered manager stated they were "Resolving these issues." During the registered manager's supervision

meeting in September 2015 it was noted the senior management team were "Concerned with Mendip" and the "Culture issue in the service." Despite this culture being known about and discussed no appropriate or effective action was taken by either the provider, the registered manager or the senior management team to address it.

The senior management above the registered manager were responsible for carrying out formal audits of the home to ensure the quality and safety of the service and line managed the registered manager. The internal audits they carried out were not effective in driving improvement. The audit carried out in January 2015 identified 78 areas for improvement. Follow up visits were carried out at two monthly intervals; these showed many areas for improvement were noted as still outstanding eight months later. These included outstanding improvements to risk assessments, health plans, epilepsy plans, behaviour plans, mental capacity act implementation, daily records, staff supervision and observation, staff personnel files and staff meetings.

A further audit was carried out in October 2015 which identified 43 areas for improvement. Follow up visits were again carried out at two monthly intervals; these showed all areas for improvement were noted as not completed six months later. These again included risk assessments, health plans, epilepsy plans, behaviour plans, mental capacity act implementation, daily records, staff supervision and observation, staff personnel files and staff meetings. There was no action taken following these audits to escalate issues so the speed at which things were being resolved could be improved. This left people within the home open to risk over a sustained period of time.

Following the serious concerns raised about people's welfare and safety in May 2016 the provider's 'nominated individual' (who is the person specifically named by the provider as the person responsible for their registered activities) carried out their own visit on 24 May 2016 to audit the home. This again showed significant widespread failings in the service including risk assessments, health plans, behaviour plans, mental capacity act implementation, daily records, staff supervision and observation, staff personnel files, environment and activities for people. The subsequent action plan showed 49 areas for improvement (21 immediate actions, 10 medium term actions and 18 longer term actions).

We found the same issues first identified by the provider in January 2015 were still prevalent during our inspection. This meant a significant number of areas for improvement had been identified over 18 months ago but had still not been acted upon. This meant people had not been protected from poor care, not had their human rights protected and the systems to monitor and mitigate risks to people and ensure governance of the service were wholly ineffective.

The provider has not ensured that people were protected from the risk of abusive and degrading treatment. Risks to people who lived at the home were not always assessed and there were no effective plans in place to manage or review identified risks. Accidents and incident recording and analysis were poor. The procedures for the administration of medicines could place people at risk. The procedures for staff recruitment did not protect people from the risk of abuse. Regular checks on hot water outlets had not been carried out, checks on the home's fire detection and alarm systems had not taken place and staff had not received fire safety training.

The provider has confirmed to us in their investigation findings they were "Concerned by the extent to which the paperwork and general regulatory compliance at Mendip House has been found to be deficient." They "Would have expected this to have been something which would have been picked up through existing regular audit processes and management oversight and it should not have taken such a whistleblowing incident to bring this to management's attention." They stated significant improvements were needed in the

governance of the service so "Such obvious failures in compliance can be readily picked up through routine management as opposed to being allowed to continue unnoticed." The provider "May also wish to consider whether there were particular failings on the part of the site manager in not recognising these compliance failures which may need to be followed up."

The actions taken by the senior management team had consistently been reactive rather than proactive. The lack of reporting to other agencies, such as CQC or the local authority safeguarding team, meant these agencies were not able to check the right action was being taken. The systems in place to monitor and improve the service were ineffective. The cultural issue within the staff team had not been addressed. A member of the senior management team when asked what was done to specifically address the serious issues at the home said "When you put it like that we didn't do anything. The whole senior leadership team is responsible for that. We failed people."

The local authority set up their own investigations team following the serious concerns in relation to people's welfare and safety being raised in May 2016. This team were overseeing an enquiry across all of the provider's services on the Somerset Court site during our inspection. They were working with key partners such as the police, the local authorities who pay for people to live at the homes and the CQC.

Relatives told us there was no formal, reliable way for them to share their views about the home. They did attend review meetings if they were able to. One relative said (if they could not attend reviews) they met separately with their family member's social worker "To discuss what was brought up." Informal events such as the family barbecue in 2015 were held. One relative said "The barbecue was over a year ago. Concerns were raised there about poor communication with parents, too many male staff, staff swearing and the lack of activities and trips. Nothing done."

The provider's aims and objectives of the home had not been put into practice. People had not been treated with "Respect, dignity and rights and value of citizenship" nor had "A meaningful community presence and the right to make decisions." People did not have a "Risk assessment when participating in activities which for them carry a high level of exposure to danger." The home had not been "Based on a commitment to quality" or "Regularly monitored, evaluated, reassessed and developed." Staff support and development had not been given "a high priority."

The home did not work in partnership with other external professionals to ensure people were safe and well cared for. Records were not kept when people saw health or social care professionals so it was impossible to ascertain who people were supported by. Discussions with staff from the local authority showed people had some support from professionals, such as support with epilepsy care, but their review reports were not kept in the home and their recommendations were not acted upon. The home had an autism accreditation review in July 2014; the home had been accredited following the review. This accreditation had subsequently been rescinded.

The service was not being operated in an open and transparent way. The provider had failed to promote a culture of openness and honesty at all levels. This should have been an integral part of the culture which ensured people's safety. There had been a failure to ensure staff at all levels understood their individual responsibilities and reported any concerns about people's care or treatment. This had contributed to the staff culture being allowed to develop and adversely affect people's lives. Local authorities who pay for people to live at the home had not always been told of significant events. One stated they were "not told of these incidents" after the person whose care they paid for had placed themselves at significant risk.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The provider had not always notified us (or other agencies) of significant events which had occurred in line with their legal responsibilities. We had been notified of some events. However, during our inspection we found one person and staff had been involved in a car accident in November 2015 where the car "Slid into a ditch and needed to be retrieved." This had not been reported us or the local authority safeguarding team. One person had left the home unnoticed without staff support and had made their way on to the main road and walked towards the next village. This had not been reported us or the local authority safeguarding team. Both of these incidents would have been considered safeguarding and therefore notifiable as 'abuse or an allegation of abuse'. This failure to report meant other agencies had not been able to review each incident and ensure the correct action was taken to ensure people were safe.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.