Westway Respite Limited

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Inspection report

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Date of inspection visit:
20 November 2018
23 November 2018

Date of publication:
23 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 20 and 23 November 2018. We told the provider the afternoon before our visit that we would be coming because the location is a respite service, therefore people and staff were not always available at the service.

The last inspection was on 27 July 2018 when we rated the service good.

We carried out the inspection of 20 and 23 November 2018 because we were alerted to concerns by one of the commissioning authorities.

Westway Respite Ltd is registered to provide two different services to adults who had a learning disability. There was a three-bedroom respite service, which offered short stay accommodation to adults with a learning disability. Up to three people were able to stay at the service at any one time. The provider is also registered to provide personal care to people living in their own homes. They were providing care to five people living in two supported living services and one person living in their own flat. However, as part of the concerns identified by the commissioning authority, the commissioners had suspended the service whilst they carried out investigations into the concerns. At the time of the inspection, two people were regularly using the respite service and a third person started using the service during the evening of the second day of our inspection.

There was a registered manager in post. 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 and associated Regulations about how the service is run .

People using the service were at risk of harm and abuse. The staff supporting them had not had the training or support to understand their needs and responded inappropriately to incidents where people were anxious or agitated. Records of incidents showed that the staff had used inappropriate restraint and restrictions. The provider had not investigated these incidents or taken any action in response to ensure people were safe and that staff learnt from these.

The provider did not ensure sufficient recruitment checks were made on staff to make sure they were suitable to care for people. They allowed staff who had not been checked, trained or had an induction to the service to support people with complex needs. This meant that people were not always getting the right support, were placed at risk of inappropriate care and treatment and their needs not being met.

The way in which staff recorded how they had cared for people indicated a lack of respect and understanding about their individual needs. There was a culture of blame where some people who used the service were seen as causing problems for the staff and were not cared for in a compassionate way.

The staff did not receive adequate training, support or supervision and the provider did not assess their competency or abilities to care for people. There was no evidence of reflective practice or support for staff to develop new skills. Whilst care plans, guidelines and risk assessments had been developed and incorporated information about people's needs, the staff did not always follow these.

Whilst some of people's needs had been met, they did not always have opportunities to live varied lives. There was limited evidence that people's sensory needs were being met, or that staff understood these. People were not supported to make use of the community and develop social interaction skills.

The relatives of people who were using the service told us they were happy with the care and support people received. They said that their relatives felt well cared for and liked the staff.

We identified breaches of seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person centred care, dignity and respect, safe care and treatment, safeguarding adults from abuse and improper treatment, good governance, staffing and fit and proper persons employed.

We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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 the risk of abuse and there were practices which restricted people's freedom and rights.

The provider did not always ensure that staff were suitable or had the qualifications, skills or experience necessary for the work performed by them.

The staff sometimes worked excessively long hours without sufficient time off placing people who used the service at risk.

The provider did not learn from incidents or investigate the way in which staff responded to incidents to make sure people were safe and to minimise the risk of reoccurrence.

Medicines were not always safely managed.

There were procedures to help prevent the spread of infection.

Is the service effective?

Inadequate

The service was not effective.

The staff did not always have the skills, knowledge or experience to deliver effective care.

People's needs were assessed and these assessments were used to create care plans.

The provider had assessed people's capacity to consent to their care. However, there were instances when people's freedom had been restricted and the provider had not responded appropriately to these.

People's health needs were assessed and they were supported to access external healthcare professionals when required.

People's nutritional and hydration needs were met.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with kindness, respect or compassion.

There was a culture in which the staff blamed people using the service rather than looked at how they could support these people.

People's choices, likes and views were incorporated into care plans.

Relatives of some people who used the service felt that staff were kind to these people.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive personalised care that was responsive to their needs.

People's formal complaints were dealt with through the provider's complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's systems for assessing and improving quality were not operated effectively and people were placed at risk of receiving unsafe and inappropriate care and treatment .

The provider had not identified or mitigated risks to people using the service to ensure their safety.

The relatives we spoke with told us they were happy with the service provided to their relatives.

Westway Respite Ltd

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.

This inspection took place on 20 and 23 November 2018. We carried out this inspection because the London Borough of Harrow, who commissioned services for six people, told us they had serious concerns about the service. We told the provider the afternoon before our visit that we would be coming because the location is a respite service, therefore people and staff were not always available at the service.

The inspection was conducted by two inspectors on each day.

Before the inspection visit we looked at all the information we held about the service. This included looking at information from the provider, including notifications, which are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also spoke with the commissioning authorities and looked at the information they shared with us about their concerns.

During the inspection, we met the registered manager and a senior care worker. No one was staying at the respite service when we visited. However, we spoke with the relatives of two people who regularly used the service on the telephone to ask for their feedback following our visit. We looked at part of the care records for four people who had been in receipt of the service. We also looked at records of recruitment, training and support for all of the staff who had been working at the service, staff rotas, incident reports, audits of the service, records of care provided, records of medicines management and records of how people had been supported with their finances.

Following the inspection visit we also spoke with two external professionals who had been working with people who used the service.

At the end of our visit we gave feedback to the registered manager.

Inadequate

Is the service safe?

Our findings

People using the service were not safe and were at risk of harm and abuse.

We identified incidents of potentially unlawful restraint of people using the service and restrictive practices. We discussed these with the registered manager and have reported our findings to the local safeguarding authority.

The registered manager showed us a file of incident reports which had been written by the staff. We looked at incident reports for September, October and November 2018.

The report of an incident which was not dated, included the statement, ''[Person] began requesting the toilet. We had closed all the toilets as [person] had just used it and wanted to restart the activity.'' There was no evidence as to why this person's access to the toilet was being restricted in this way. This practice was not an approved technique in their care plan and might have constituted a breach of their human rights. The incident report went on to say that the person later, ''ended up urinating on the bedroom floor.'' This incident of a potentially unlawful restraint had not been investigated by the provider. We discussed this with the registered manager who told us they were unaware of this incident.

The report of another incident which was also not dated, included the information, ''[person] slipped back and hit [their] left shoulder on a radiator. [Person] then began stating that we [staff] had pushed [them] and continued adding onto the claims.'' The report then stated, ''we got [person] upstairs in [their] bed at 23.30 where [person] pleaded to let [person] call the police. We denied this based on the events that occurred and didn't see it fit to involve police as [person] often pushes and hits staff.'' There was no evidence that this had been investigated by the registered manager and they told us they were unaware that the incident had taken place. The staff had failed to follow safeguarding procedures to ensure that the person's allegation was reported to the correct authorities and investigated. There was no evidence to counter the person's claim that they had been hit by the staff, except the account written by the alleged abusers.

There were also records which showed that the staff had used restraint techniques. These were not part of people's care plans. The staff had not received training about how to safely use physical interventions. For each of the incidents there was no analysis of what could have triggered the incidents, no investigation into what happened or whether the staff response was appropriate and no evidence of reflection so that the staff could learn from these incidents and improve their practice. Incident reports from events in September and October had a note to state, ''form seen'' by the deputy manager on 2 November 2018. In one case this was over seven weeks after the incident. We discussed this with the registered manager who told us they were unaware of the majority of incidents reports we showed them. There was no evidence of the investigation of any of these incidents or discussions with staff about these. None of the incidents had been reported to the local safeguarding authority or commissioners.

One incident report from 13 September 2018, recorded that ''restrictive physical intervention'' had been taken against one person. The record stated that five different members of staff had restricted the

movement of the person's arms over a period of one and a half hours. The care plan for this person did not include any reference to restrain t of the person's arms. The plan stated that if the person became very anxious, ''If required trained staff can use Studio III techniques, such as two person walking from one room/environment to another, filtering and other escape techniques.'' There was no evidence the staff supporting this person had been trained in these techniques. Furthermore, the incident report stated that four members of staff had used a ''walk around'' restrictive intervention. There was no evidence that the use of restraint had been investigated.

The report of an incident on 26 October 2018, stated that five members of staff ''had to apply restraint procedures [to a person], the incident escalated and staff administered PRN [as required] medicines.'' There was no record of the type of restraint or how long this took place for. There was also no analysis of why and how the incident, ''escalated.'' The form stated that one person using the service had been injured. There was no record of whether this was the person who was restrained or another person or what type of injury. There was no evidence this incident had been investigated.

Two incident reports on 3 and 12 October 2018 stated that the staff had lifted a person up. In both incidents the person was sitting on the pavement outside of the house. The report of the incident on 12 October 2018 stated the person was, ''supported to the house by being lifted up by four members of staff.'' The registered manager told us that the person had not been physically lifted and this was a mistake because of the English language skills of the staff recording this incident, however both reports had been written by different members of staff. There was no analysis to suggest the incidents had been investigated or evidence to show that a different technique had been used. The person's care plan did not include the technique of lifting as an approved technique. Furthermore, the incident reports did not state why the person was forcibly moved back into their house rather than supported to remain where they were.

The reports of incidents lacked important details about what had happened and why the staff made the decisions they did. There was no analysis of these incidents to make sure the staff had responded appropriately to the situations described in the incident reports. For example, one incident report from the 13 September 2018, stated the staff, ''Tried to prevent [person] from climbing on the [kitchen] counter'' and ''[Person] had to be brought down and put in the sensory room.'' The incident report did not explain whether this was through physical interventions. There was no evidence that the registered manager or staff had reflected on what had occurred and whether they could learn from this.

The report of an incident on the 13 October 2018, stated that a person went inside their bedroom and locked the door. The incident report went on to record that a member of staff unlocked the door and asked the person why they had locked their door. The person then became anxious and the report states, ''[Three members of] staff had to restrain [person] from getting harmed.'' There was no description of the type of restraint of length of this. There was no evidence this incident had been investigated by the management team or information to state why the staff had unlocked the person's bedroom door.

The report of another incident which was not dated stated that a person wanted to enter the kitchen but ''the staff had to stand in [their] way.'' The report went on to state, ''using the proper techniques, staff were able to apprehend and relocate [person] to the hallway.'' There was no further information about this and what the 'proper techniques' entailed. The incident had not been investigated and when we spoke with the registered manager they told us they had not seen the incident report before.

One of the local authorities who commissioned care with the provider were investigating allegations of abuse, which had also been reported to the police. The investigation into these allegations was taking place at the time of the inspection and we are not able to report on these. However, the commissioners identified

that the provider had failed to safeguard people from abuse or keep them safe.

We looked at some of the records relating to how people using the service were supported to spend their money. The records for one person's financial transactions in September 2018, stated, ''Short £77.23.'' There were no other records relating to this incident. We discussed this with the registered manager who explained that the staff working at the service had been told to contribute money each to reimburse the person. The incident had not been reported to the police or local safeguarding authority. There was no evidence of an investigation into this incident. The registered manager told us that the money had later reappeared and therefore they did not realise that they should have taken further action. The provider did not follow their own procedures or those of the local safeguarding authority in reporting this or investigating what had happened. The way in which they responded did not safeguard people from abuse.

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

The provider did not always ensure that staff were suitable because they had not carried out sufficient checks on the staff during recruitment or since. The registered manager told us that there were seven members of staff employed by the provider, four support workers and the management team. The provider had not carried out sufficient checks on the suitability of the four support workers.

One support worker had been issued with a contract stating they commenced employment on 16 July 2018. This staff member had completed their application for employment form on 12 July 2018. They had recorded two previous employers on their application form, but the information about one of these was incomplete. They had not recorded any employment before December 2017 or any reason for not working. They had given the name of one referee. There was no evidence of a recruitment interview or that the provider had sought assurances of how this staff member had spent their time before December 2017. The referee had completed a reference about the staff member, but this was written on 11 October 2018 and had been signed as seen by the registered manager on the 15 October 2018. Rotas for the service showed this member of staff had been working as part of the staff team since July 2018, for three months before the reference was received.

Another support worker had completed an application form on 27 June 2018. Staffing rotas showed that they had been working at the service since July 2018. However, there was no evidence of any references from previous employers, of a satisfactory check from the Disclosure and Barring Service regarding any criminal records or evidence of a recruitment interview.

A third support worker had completed an application form on 1 July 2018. They had listed only one previous employment which had started on 6 April 2018. There was a reference from another employer which stated that the member of staff worked for them but did not give information about their conduct or experience. There was no record of interview. Staffing rotas showed that this member of staff had also worked for the service since July 2018.

All other support workers were sourced from one of two employment agencies. These types of employment agencies are not regulated by CQC and registered providers have a responsibility to ensure sufficient recruitment checks are carried out by the agency and that the staff have the skills and knowledge to work at their service.

The registered manager told us that they had obtained profiles on each member of staff from the employment agencies which gave basic information about recruitment checks and the training the staff had

undertaken. However, there were no profiles in place for four of the agency staff who were scheduled to work at the service on the planned staffing rota for September and October 2018. Records of staff hand overs, incident reports and logs of care provided showed that these four agency staff and a further three other members of staff from the agency, for whom there were no profiles, had worked at the service supporting people. There were no other records to show that checks on the suitability of these staff had been made.

The above evidence showed that the provider had not undertaken sufficient checks to make sure the staff were suitable to work at the service .
This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not deploy sufficient numbers of staff of appropriately qualified, skilled and experienced staff which led to staff sometimes working excessively long hours without sufficient breaks. This placed the staff and people at risk of harm because the staff might not have received adequate rest between shifts. The provider could have also been putting the health and safety of staff at risk.

For example, a rota showing 28 days in July 2018, showed that one member of staff worked for all 28 waking nights (12 hour shifts). The registered manager confirmed they had worked these shifts. For August, September and October 2018, the same member of staff worked six waking night shifts in a row every week. A second member of staff worked 27 days (12 hour shifts) during 28 days in July 2018. And a third member of staff worked 16 days (12 hour shifts) in a row, with one day off and then worked a further 10 days during the same 28 day period in July 2018. The registered manager told us that they had difficulties with staffing levels in July 2018 but could not explain how they had ensured these members of staff, and others who had also worked long days consecutively, had sufficient breaks to make sure they were competent and safe to carry out their work.

With the exception of one member of staff working eight days in a row from 28 October 2018 to 4 November 2018, the staff were assigned at least one day off in each calendar week for August, September and October 2018. However, five members of staff worked six 12 hour shifts each week. The incident reports and logs of care indicated that there were regular occurrences where the staff were kicked, hit or pushed by people using the service. This working environment could further add to the stress or tiredness that workers felt, placing people using the service and the staff at risk of harm.

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

There were appropriate recruitment checks in respect of the three members of the management team.

The risks assessments and plans for reducing incidents of risk were clearly recorded, as was information about how to support people with different risks to their wellbeing. The provider had used a traffic light system for indicating levels of risk relating to people's mental wellbeing and anxiety. However, records of incidents that had happened at the service, (as described above) indicated that staff did not always follow the guidance in order to keep people safe.

The provider did not ensure care was provided in a safe way because the staff providing care did not always have the qualifications, competence, skills or experience to do so safely. One person had epilepsy, a condition which can cause seizures. They were prescribed a medicine to be administered as required (PRN) during certain types of procedures. The PRN protocol for this medicine, written by the community nurse on

23 March 2018, stated that if a seizure lasted longer than three minutes trained staff should administer this medicine. During November 2018, the logs of care provided to this person showed that at least 11 different members of staff had been responsible for their care during this time. There were no records for any training for three of these members of staff. Of the other eight members of staff, only two had received training in relation to epilepsy and there was no evidence that any of them had been trained to administer this type of medicine. Therefore, they did not have the skills or experience to meet this person's needs in the event of them experiencing a seizure.

The care plans for three of the four people we looked at referred to staff using physical interventions when people became agitated. The care plans stated that physical intervention should be used as a last resort and only by staff trained in ''Calm'' or ''Studio III'' techniques. Of the 18 staff recorded on the rota for October 2018 and the additional five other staff who had worked, (according to logs or incident reports), only three members of staff had a record to show they had undertaken any training in aggression, violence or management of challenging behaviour. The records for two of these staff indicated this training had been part of a one day training course covering over 10 other subjects. There was no record of training for the use of physical intervention. The reports of incidents in September and October 2018 suggested that at least 14 different members of staff had been involved in the physical restraint of people using the service. There was no evidence that any of these staff had received training in physical intervention techniques.

Medicines were not always managed in a safe way. The provider's records showed that at least 14 different staff were assigned the responsibility of administering medicines during October 2018. Records showed that one other member of staff had administered PRN (as required) medicines to one person during this time. The profiles and training records for 13 of these staff did not include any evidence of training about medicines management. There was no evidence that any of the staff member's competency at administering medicines had been assessed. We asked the registered manager about this. They said that the week before our inspection, ''about nine members of staff'' had received training regarding medicines, but they did not have evidence of this. They said that they had not assessed the competency of any staff to administer medicines.

Two people were prescribed PRN medicines for agitation. The guidelines in one person's care plans stated that the ''on call manager'' must agree to the administration of these medicines. Records stated that the staff administered PRN medicines to the person on 16 September 2018, 1 October 2018, 10 October 2018, 5 November 2018 and 6 November 2018. The reports of 16 September 2018 and 1 October 2018 had been signed and approved by the deputy manager on 2 November 2018. There was no indication that a manager had authorised the use of this medicine before this date, or on any of the other four occasions when it was administered.

The protocol for the administration of this medicine written by the consultant psychiatrist in June 2017 stated that it should be administered for ''increasingly aggressive or challenging behaviour.'' With additional guidelines written by the deputy manager in June 2018 stating that the medicine should be administered in ''extreme cases'' and ''in event of [person] displaying physically challenging behaviour.'' The 'service user report' for the 5 November 2018 stated, ''There was no major incident, just shouting and administered PRN to calm [person] down.'' Therefore, the staff had not followed the guidance around the appropriate administration of this person's medicines.

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

Two people were using the service at the time of our inspection. We spoke with the relatives of two of these

people who told us they felt their relatives were safely cared for. They said they had the same familiar staff who the relatives felt knew people's needs.

The provider had procedures for prevention and control of infections. The staff were supplied with personal protective equipment, such as gloves, to help minimise the risk of infection spreading.

Inadequate

Is the service effective?

Our findings

The staff did not have the skills, knowledge or experience to deliver effective care and support. There was no evidence to show that seven members of staff sourced from employment agencies to work at the service in September and October 2018 had undertaken any training relevant to the roles they were performing. The profiles detailing the training for the other staff showed basic care work training, the majority of which had been undertaken during a one day training course covering a range of different subjects.

There was no evidence of any training, qualifications or certificates for three of the four members of staff who had been recruited by the provider during 2018. One of the members of staff had undertaken a one day training course covering 16 different subjects.

We asked the registered manager what kind of induction the staff received when they started working at the service. They showed us an induction checklist and told us that senior staff went through this with the new member of staff. There were no induction checklists for 10 of the support workers who worked at the service during October 2018, and no other evidence to show they had received any form of induction when they started working there. The induction checklist listed the following areas of induction, ''Use of TEACCH, record keeping, individuals using the service, public, other staff, other professional obligations, aims and objectives, missing persons procedures, fire evacuation procedure and quick view profile.'' TEACCH is a nationally recognised Autism Training programme. There was no evidence the staff had undertaken this training, which included a five-day classroom based learning to the approach. All areas of the induction checklist had been signed on one day.

There was no evidence that people had shadowed existing care workers as part of their induction, although the registered manager told us this had happened. There were no records to indicate that staff competency had been assessed to make sure they had the skills and knowledge to care for people.

There was no evidence of medicines management training for the staff or training in communication techniques or managing challenging situations. The care plans for people who used the service showed that they had a variety of different communication needs. There was no evidence that the staff had been trained to support people to use different equipment or with non verbal communication. The registered manager told us that this training had been provided by a visiting speech and language therapist. They gave us this professional's contact details. We spoke with the therapist. They said that they had visited the service, supported individual people and spoken with staff but had never provided any training for the staff. They also told us that the last time they visited the service was in March 2018 so had not worked with any of the staff employed since this time.

People's care plans indicated that they sometimes expressed their anxiety through physical and verbal challenges. There was no evidence the staff had been trained about appropriate ways to respond to this. Three people's care records we looked at stated that staff trained in specific physical intervention techniques could use physical restraint as a last resort when people became 'very' anxious. There was no evidence that any of the staff had received training or guidance about the specific training referred to in the

care plans.

Staff meeting minutes indicated that there had been staff meetings every two weeks. However, these did not include any evidence of learning or reflective practice. The minutes of all meetings in September and October 2018 stated, ''To source Medication training, Calm training and PBS (positive behaviour support) training.'' However, there was no evidence this training had taken place or any further discussion about this with staff, such as sharing guidance or using resources from the training providers' websites. Skills for Care is a national organisation who work in partnership with the Department of Health to provide training resources and guidance for health and social care providers. They have produced documents such as, ''Autism skills and knowledge list, for workers in generic social care and health services'' and the ''Learning Disabilities Core Skills Education and Training Framework.'' There was no evidence the provider had accessed these, or other relevant resources, to support the staff to have a better understanding of the people who they were employed to support.

There was no evidence of individual supervision meetings or reflective practice for the majority of the staff. There were records of one individual meeting during 2018 for four of the support workers, two of these support workers were still working at the service in October 2018. There was no evidence of individual meetings with any of the other support workers, nor any induction or probation meetings with the staff who had been employed in 2018. This meant the provider was not was not adequately supporting staff in their role or monitoring and addressing their performance and wellbeing to ensure they provided effective care.

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

The provider had carried out assessments of people's needs before they started using the service. These assessments identified their individual needs and ways people communicated. These assessments were used to develop a series of risk assessments and care plans which outlined how people should be cared for.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The provider had undertaken assessments of people's mental capacity. There were records to show the assessments which had been undertaken. However, there was evidence of practices which restricted people's rights and freedom, such as the unauthorised administration of medicines and physical interventions, such as restraint. The provider had not investigated these.

People's health care needs were recorded in their care plans. The staff kept logs of care provided which included information about people's health and wellbeing. There was evidence people had been supported to see healthcare professionals when needed.

People were able to make choices about the food they ate. The staff supported people to buy and prepare the food they had chosen. Logs of support provided indicated people had varied diets and were offered regular drinks.

Inadequate

Is the service caring?

Our findings

The staff were not always caring, kind or supportive of the people who used the service. Records of care provided and incident reports indicated that the staff did not understand when people were anxious, scared or upset. The staff responded to these situations in a way that placed blame on the people who they were employed to care for, instead of supporting them, protecting their rights and advocating on their behalf. The staff used language and phrases when reporting on incidents which demonstrated they had little or no awareness of the complex needs of the people who they were supporting and saw themselves (the staff) as victims. For example, a number of incident reports stated, ''[Person using the service] was verbally abusive to the staff.'' One incident report described a person being physically restrained by the staff and then went on to say, ''[Person] felt instant guilt and regret.'' Another incident report stated the person had ''apologised to the staff for ruining their night.''

This culture of blame was reflected in the attitude of the registered manager who described one person who used the service as being ''persuasive'' and ''making up allegations'' about staff resulting in ''some good staff losing their jobs.'' The majority of incident reports involved a number of staff intervening verbally, sometimes physically, to restrict people using the service. The descriptions of these included restrictions of people's human rights, such as needing to use the toilet and asking to report an allegation that they had been physically assaulted. One log of care stated that the person wanted to access the kitchen but ''staff denied [person] access and [person] became abusive.'' Another log stated, ''[Person] had challenging behaviour because [they] wanted chocolate and crisps.'' There was no recognition by the staff that they were denying this person their rights. Because there was no reflective practice or supervision of the staff, this staff behaviour and attitude was allowed to continue.
The above shows that people were not being treated with dignity and respect and in a caring and compassionate way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included person centred plans which had been developed, to some extent, with the person they were about. People's likes, dislikes and preferences had been recorded.

The relatives of two people who used the service told us they thought the staff were caring towards their relatives. One relative told us, ''There are familiar staff and [person] us always happy to see them.'' The other relative said, ''[Person] is relaxed and happy with the staff. [Person] is very close to them and they communicate well with [person].''

One of the professionals who we spoke with told us they had last visited the service in March 2018. They said that they had, ''a good feeling about the place'' and the interactions between staff and people using the service which they had witnessed had been positive.

Requires Improvement

Is the service responsive?

Our findings

People's needs were not always being met. The staff supporting people did not understand their needs. People who used the service had learning disabilities, autism and some people had additional mental health needs. The National Autistic Society, a charity dedicated to funding and providing support and research into supporting people with autism, has produced guidance that stated, ''Autistic people may appear to behave unusually. There will generally be a reason for this: it can be an attempt to communicate, or a way of coping with a particular situation. Knowing what causes challenging behaviour can help you to develop ways of dealing with it.'' They produce guidance around acknowledging and responding to people's sensory needs and anxiety. Similar good practice guidance is available for supporting people with learning disabilities and mental health needs, with the key acknowledgement that verbally or physical aggression is usually linked to a person's anxiety or need to communicate.

Records of care provided at the service showed that the staff had limited, or no, understanding of this guidance or any other national guidance to care for people learning disabilities. For example, extracts from the logs of people's care included the following comments, ''[Person] did not want to calm down'', ''On seeing [another person] present challenging behaviour it is as if [person] wanted to join in'', ''[Person] attempted to portray some challenging behaviour, [they were] spoken to and calmed down'' and ''[Person] was in the living room wanting attention.'' These examples, along with other records, such as records of incidents, demonstrated a lack of staff awareness about people's sensory and communication needs and a failure to acknowledge people's anxiety or distress and to respond to their individual needs. Furthermore, the incident reports showed that the staff response to this communication was usually one that escalated the situation further.

People were not always supported to participate in a variety of meaningful activities. For example, the care plan for one person described them as liking, ''community based activities, reading, gardening, music, art, shopping, bowling and going out for dinner.'' The logs of care provided to this person from 1 – 16 November 2018, showed that they had taken part in two hour long art sessions, two aromatherapy sessions, been bowling once, seen their family once and went on one trip to a museum which was cut short because of an incident. There was no evidence of other community based activities, support to develop their skills and interests or therapeutic support. The care records for another person described them as liking, ''walking and running in open spaces, swimming and listening to music.'' The logs of care provided to this person for 1 – 16 November 2018, showed that they had been bowling four times, visited a museum, had two aromatherapy sessions and one art session and had been for three ''drives.'' There was no evidence of other community based activities or opportunities to take part in the activities recorded in their care plan.

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

The care plans for people using the service were clearly laid out and included information about how to support people to reduce their anxiety.

The provider had an appropriate complaints procedure . We looked at records of complaints and saw that these had been responded to and resolved to the complainant's satisfaction .
The provider was a respite service and did not offer support to people at the end of their lives or with palliative care.

Inadequate

Is the service well-led?

Our findings

During the inspection we identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager's response to our findings was to apologise that they had, ''taken their eye off the ball'' and placed too much responsibility on others to manage aspects of the service. They were unable to explain the circumstances around a number of failings and could not evidence any investigation into allegations of abuse or where staff had use d restraint.

The provider's systems and processes were not operated effectively to assess, monitor or improve the quality of the service. The provider and staff did not reflect on their practice, so they could learn from this and make improvements. People using the service were not adequately supported to develop new skills, and their emotional, communication and sensory needs were not always being met. People did not always receive a quality service and some people received a service which caused them distress and put them at risk of harm.

The provider's systems and processes did not effectively identify and mitigate risks. The staff approach to incidents of physical and verbal aggression from people who used the service did not follow their planned care, was not in line with recognised good practice and caused situations to escalate. When failings were identified, such as the instance when a person's money was found to be missing, the provider's response was inappropriate and did not mitigate the risk of this happening again in the future. The provider had not identified when staff had used inappropriate restraint because the registered manager had not assessed or analysed the reports of incidents or discussed these with the people using the service or staff.

The staff providing support to people had not been sufficiently trained, and their skills and competency had not been assessed. This meant that they were not always meeting people's needs or caring for them in a safe way. The provider had not always followed their recruitment procedures robustly to check staff members' suitability to work at the service before they started working there.
The provider undertook audits of health and safety and the environment. They had also carried out weekly audits of the supported living services. These had identified similar concerns at each visit. For example, ''logs need to be more descriptive and detailed'', ''incident reports need to be more descriptive'' and ''all food intake needs to be recorded.'' There was no evidence that action had been taken to resolve these issues .

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

Notwithstanding the serious shortfalls we found during the inspection, the relatives of two people who used the respite care service said they were happy with the way the service was provided for their family members. One relative said, ''We are very happy, [person] has been using the service for a few years.'' The other relative told us, ''I am really happy with the whole set up, if I have any concerns I ring [the registered manager] or [deputy manager] and they help out.''

One professional who had worked with the service over a period of months up until March 2018 said that

they had found the staff receptive to their ideas and approaches.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9(1)

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure people were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have issued a notice of proposal to cancel the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not provider care and treatment in a safe way because they had not: Done all that is reasonably practical to mitigate any such risks. Regulation 12(2)(b) Ensure that persons providing care to service users have the qualifications, competence, skills and experience to do so. Regulation 12(2)(c)

	Ensured the safe and proper management of medicines. Regulation 12(2)(g)

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure that service users were protected from abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of service users or investigate allegations of abuse. Care and treatment was provided in a way which included acts intended to control and restrain service users that were not a proportionate response to a risk of harm posed to the service user or other individuals, was degrading to the service user and significantly disrespected the needs of the service user for care or treatment. Regulation 13(1), (2), (3) and (4)

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate systems and processes to enable them to assess, monitor and improve the quality and safety of service users. 17(1) Regulation 17(2)(a) The registered person did not operate systems and processes to assess monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

	Regulation 17(2)(b) The registered person did not maintain securely records relating to persons employed and the management of the regulated activity. Regulation 17(2)(d)

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that persons employed were of good character, had the qualifications, skills, competence and experience necessary to carry out the regulated activity. Regulation 19(1)(a) and (b) The registered person had not operated effectively processes to ensure that persons employed met these conditions because they had not obtained the information as set out in Schedule 3. Regulation 19(2)(a) and (3)

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure that enough suitable staff were deployed or that persons employed received appropriate training, support, supervision or appraisal to enable them to carry out the duties they were employed to perform. Regulation 18(1) and (2)(a)

The enforcement action we took:

We have issued a Notice of Proposal to cancel the provider