Safeharbour West Midlands Limited

Safeharbour (260 Hagley Road)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 07 and 08 March 2018 and was unannounced. The service was last inspection in November 2016 and at that time was rated as good.

Safeharbour is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Safeharbour accommodates six people in one adapted building. At the time of the inspection, five people were living at the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. The service did not consistently comply with Registering the Right Support and the registered manager was not aware of the policy.

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 2008 and associated Regulations about how the service is run.

People were not fully protected from harm and abuse. Accidents and incidents had taken place and had not been reported to the appropriate authorities. Potential safeguarding concerns had not been recognised and acted on appropriately. Systems were not in place to collect this information and learn lessons.

Systems in place to respond to behaviour that may challenge did not provide staff with enough detail on how to use de-escalation or distraction techniques. Restrictions were in place which significantly limited people's choice and control regarding their participation in daily activities.

There was a lack of good governance and oversight of the monitoring and administration of medication. Staff competencies in administering medication were not assessed, protocols were missing and medication audits in place had failed to identify areas of concern.

Systems were not in place to ensure staff had the skills, knowledge and experience to deliver effective care and support. Not all staff had received training in specialist areas and staffs competencies were not being assessed.

People were supported to maintain a healthy diet and staff were aware of people's dietary needs and preferences. People were not always supported to maintain good health. Staff did not routinely obtain healthcare advice or guidance when people were unwell.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

Staff were described as kind and caring but for some people, communication systems in place were not effective and did not provide staff with the information and training to communicate with all people effectively.

People were not routinely involved in the planning and development of their care. People were supported to access a wide variety of activities during the day, but did not always have their wishes respected if they did not want to participate in some of the activities.

People's care records provided staff with detailed information about them, but were repetitive and difficult to navigate.

Relatives were confident that if they raised a complaint, it would be dealt with appropriately.

There was a lack of oversight of the service by the provider and the registered manager. There was a distinct lack of audits in place that would provide the registered manager with a view of what was happening at the service. The audits that were in place were ineffective, inconsistently completed and did not highlight the areas of concern that came to light during the inspection.

The provider had not informed CQC of important events that occurred at the service, in line with current legislation.

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 did 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.

Concerns of a safeguarding nature were not routinely raised or reported to the appropriate authorities. Accidents and incidents were recorded but not analysed for patterns or trends. Medication management processes and protocols were not consistently followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported by staff who had received all the training they needed to meet people's needs. People were not consistently supported with their healthcare needs. Decisions made in people's best interests were not routinely recorded. People were not consistently supported to make choices regarding their daily activities.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People described staff as kind and caring. Communication care plans were inconsistent and did not provide staff with the information or training to communicate effectively with all the people living at the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were supported to take part in a variety of activities and to access the community on a regular basis, but did not always have a choice in this.
Relatives were confident if they raised a complaint they would be listened to.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager and provider did not have adequate oversight of the service. There was a lack of audits in place to ensure lessons were learnt, accidents and incidents were reported and acted upon and ensure CQC registration requirements were met.

Safeharbour (260 Hagley Road)

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident regarding an allegation of abuse. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk regarding the safe care and treatment of people living at the home. This inspection examined those risks.

We considered the current risks to people and the actions the provider was taking to mitigate those risks. We saw that additional support was provided to the service by the Local Authority and Clinical Commissioning Group, in terms of staff training.

This inspection took place on 07 and 08 March 2018 and was unannounced. The inspection was carried out by two inspectors.

We spoke and met with representatives from the local authority and clinical commissioning groups. We spoke with the provider, the registered manager, three members of administration staff, seven members of care staff and three visiting professionals. We also spoke with three people living at the service. Following the inspection we had phone conversations with five relatives and a healthcare professional who specialised in medicines management.

We reviewed a range of documents and records including the care records of three people using the service, four medication administration records, three staff files, training records, accidents and incidents,

complaints systems, minutes of meetings, activity records, surveys and audits.

Inadequate

Is the service safe?

Our findings

At our last inspection in December 2016, the provider was rated 'Good' in the question 'is the service Safe?' Following this inspection we have changed the rating to 'Inadequate' based on our inspection findings.

The provider had failed to implement systems and processes to keep people safe from avoidable harm and abuse. We saw a number of potential safeguarding concerns were not being identified by the provider from incidents, restraints or accidents, which included injuries to individuals. Further, the provider had failed to notify the Local Authority and the Care Quality Commission of these events, as is required by law. Staff spoken with told us they had received training in how to safeguard people from abuse and said if they were concerned for people's safety, they would report this to the registered manager immediately. However, we found no evidence of staff reporting these concerns following the incidents that we identified. This meant the provider was not aware of the possible safeguarding concerns and as such was unable to act on these to ensure people were protected from abuse and improper treatment.

From records seen, we saw that risk management in the home included restrictions on people which significantly limited their control over their lives and their independence. We noted there was a practice of using restraint to restrict their choice and control over their lives. For example, we found evidence of people refusing to go out for a walk. In a number of incidents, we found evidence of staff using MAPA [Management of Actual or Potential Aggression] techniques to force a person to go out of the building or staff being told not to interact with person if they could not get them out of the building. MAPA techniques are used to provide staff with the skills to help people who are aggressive or violent, to calm down through actions and words. One incident recorded stated, "[person] was requested to put their coat on. They refused, despite persistence of carer.' The recording went on to state the person was showing signs of agitation, and that a decision was made to use MAPA level 2. We also noted, in one care file, staff were instructed if a person did refuse to leave the building, 'Do not interact with [person], just given basic instructions'.

We observed information held in people's care records provided staff with information regarding the behaviours that may challenge that people presented and how to respond to them. However, care records failed to provide staff with information regarding how to distract a person and de-escalate a situation prior to a particular behaviour. After each incident of restraint, there was no evidence to identify who had overseen the report or any review of the actions taken. We saw that these events were recorded, but there was no system in place to analyse the information and look for themes and trends. We saw the monitoring of challenging behaviour incidents was not recorded consistently and the registered manager did not have oversight of this. We looked at the service's Restraint Policy and noted that staff should be analysing each incident after it had occurred but we found no evidence that this was taking place and therefore no opportunity to learn from each event.

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

Staff told us there were enough staff to meet people's needs, but not enough time to complete paperwork

and review care files. One member of staff said, "There is a lot of paperwork at the moment and I'm trying to get to speak to [registered manager's name] about reducing files". As key worker I should be going through the whole file to see what needs changing but we haven't got enough staff to give us time to do this". We observed that staffing levels in place were based on people's needs and where it was identified that people should be supported by two staff, these arrangements were in place. The registered manager told us their staffing structure included two team leaders, but that they had been without a second team leader for over 12 months and wanted to 'recruit from within'. They told us they felt existing staff were not ready to move up to the next level but we found no evidence of staff being mentored or supported to take up this role. This meant opportunities were lost to recruit to the vacant post and support the existing staff group.

Staff told us that prior to commencing in post, they were required to submit two references and a Disclosure and Barring [DBS] check; this check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed. We found the registered manager had failed to complete a risk assessment for a member of staff following information that came to light through their recruitment process. We raised this with the registered manager. They told us they had not completed a risk assessment and had spoken to the member of staff and were happy with what they told them.

We looked at the medication administration records [MARS] of four people. Of records sampled, we found where medication that was recorded as given, the amount signed for tallied with the amount that was in stock, with the exception of one record. We found for one person, the member of staff had failed to sign to say they had administered one medication that morning. The registered manager checked with the member of staff that the medication had been administered. They confirmed it had. We saw for another person, their topical medication had not been applied for two days and a body map, which would indicate where the cream should be applied, had not been filled in. We observed a member of staff administer a person with their medication. The member of staff explained what was happening and encouraged the person to take their medication without rushing them, and praised them afterwards.

Staff signed to say if they took people's medication out of the home for administration during an activity and policies and procedures were in place regarding this.

We found that for people who required medication 'as required' for example, medication to reduce anxiety, the protocol in place did not provide the person in charge with enough information that would allow them to make an informed decision as to whether or not to administer the medication. For example, one protocol stated, 'If [person] has displayed aggressive challenging behaviour for 20 minutes or more administer [medication]'. However, it did not describe what the behaviour may look like for that individual nor did it provide staff with details of other distraction techniques that could be considered prior to administering the medication. We saw that each person's MAR record had a photograph and the date it was taken but failed to name the person in the photograph. There was a signature chart in place for staff who administered medication to sign, but not all staff signatures were recorded. We saw handwritten entries on the MAR charts for new drugs which had not been signed and checked by two people. We saw another person's boxed medication clearly labelled to say it should be administered at 8.00 am but the MAR chart had been handwritten and highlighted that this medication should be administered at 8.00 pm. This entry had been signed by two staff both of which had failed to recognise that the entry on the MAR was incorrect and should have been administered at 8.00 am. We raised this with staff who all told us, "No, it should be administered at 8.00 pm". Staff agreed to follow this up with the dispensing pharmacy to ensure the information they had was correct.

We noted there was a system in place to stock what was called 'emergency medication'. We were told these

were additional items of stock in case people's medication ran out. However, there was no auditing of these stock levels which ideally could be managed through the monthly auditing and ordering of medication. We advised the registered manager that it was not good practice to stock pile medication and they told us, "I know". Staff who administered medication told us they received training to do this but told us they were not aware of their competencies being assessed in this area. We spoke with the registered manager regarding this. They told us they relied upon a team leader to conduct staff competencies in the administration of medication but were unable to provide any evidence that this had taken place. We spoke with a healthcare professional following the inspection, who had looked at the medication systems in place. They had provided guidance to the provider on actions to take but told us there was a "Blatant disregard with respect to medication policies and procedures" at the home.

We saw the last medication audit in place was completed by a senior member of staff the day before the inspection and had failed to identify the areas of concern that were highlighted during the inspection. The registered manager told us, "Medication audits should be weekly, but they aren't always". We saw that they did not take place regularly. The registered manager told us, "I do look at it [medication records] but I haven't written it down".

Staff advised us that PPE was available for them to use and raised no concerns regarding this. We observed the home to be clean and odour free, but noted the last infection control audit took place in 2016.

We found that systems were not in place to ensure lessons were learnt when things went wrong. There was a collection of information regarding the number of incidents people were involved in and the time, date and location of the incidents. However, there was no analysis of this information that would demonstrate that lessons had been learnt from the incidents. Further, we saw where incidents had been recorded in some care records, the number of incidents recorded in other documentation was incorrect. For example, we counted in one month 26 incidents had been recorded against the name of one person, but paperwork which was supposed to keep a log of this information recorded the number as two. This meant that even if this information had been analysed, the registered manager could not be confident that the figures were correct as systems in place had failed to record the correct numbers.

Relatives spoken with talked positively of the service and considered their loved ones to be kept safe from harm. We received the following comments; "[Person] is safe, well cared for and loved", "I have always believed [person] is safe there. I have never felt they were unsafe" and, "[Person] has always been looked after, they are ever so safe there".

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2016, the provider was rated 'Good' in the question 'is the service Effective?' Following this inspection we have changed the rating to 'Requires Improvement' based on our inspection findings.

People's healthcare needs were not routinely met and we saw people's access to healthcare services was inconsistent and healthcare plans were not fully completed. Meetings and conversations with other healthcare professionals were not consistently recorded, making it difficult to evidence that healthcare issues had been followed up and acted upon. We spoke with the registered manager about this and they told us they realised it would be a 'good idea' to record these meetings. We saw examples where people had been referred to their GP, supported to attend hospital appointments to see specialist healthcare providers, such as speech and language therapists and epilepsy nurse, in order to meet their needs, but also noted incidents where people had sustained injuries but efforts had not been made to seek medical assistance. For example, we saw in one person's records they had banged their head against a car. The incident was recorded but no medical assistance was sought to ensure the person had not sustained an injury. This was particularly concerning, as the person was unable to communicate verbally and there was no evidence to indicate that staff had attempted to ask the person if they were in pain or felt unwell. A relative told us how they had noticed their loved one was limping badly. We saw that prior to the relative noting this, staff had referred the person to the nurse practitioner. it was felt the person was limping due to wearing new trainers. However, the problem persisted for a further eight days. The relative told us, "I took [person's] shoes and socks off and saw swelling on their foot; this is the kind of thing they should notice; it should not take me to highlight it". We saw that the person had been taken to hospital and an x-ray revealed they had sustained a stress fracture and also noted an historical stress fracture.

This is a breach of Regulation 12, Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities)

One relative told us, "I am convinced they [staff] deal with [person's] health care needs, absolutely". Staff spoken with were knowledgeable regarding people's healthcare needs and relatives told us if their loved one was unwell medical intervention was sought. However, this did not reflect what we found on inspection.

Staff told us their induction prepared them for their role and included reading care plans and shadowing more experienced members of staff. One member of staff told us, "There is a lot to learn. You get to know people". Staff confirmed they received supervision regularly and we saw evidence of this. One member of staff said, "I can have supervision when I need it; it's usually every 6 weeks with [registered manager's name]; she is good". There was a training matrix in place which provided the registered manager with the dates of training attended by all staff. One member of staff told us, "We do get a lot of training". Another member of staff said, "We need more autism training, what we've had is very basic. We've also had workshops with the senior staff about individuals". We were provided with a copy of the most up to date training matrix. We noted that all staff had received MAPA training [training in how to safely support people who may present behaviours that challenge], but for three staff the training had very recently expired. The registered manager

told us plans were in place to conduct refresher training the following week. The registered manager confirmed they were not trained in MAPA techniques and relied on their team leader to oversee staff practice in this area, but we found no evidence of this taking place.

We saw that five staff had not received any training in autism awareness and for two other members of staff (one being a senior carer) their autism training consisted of watching a DVD. This, coupled with the fact that staff competencies were not taking place, meant the provider could not be confident that all staff supporting people had the skills, knowledge and competence that is required to meet the needs of people living at the home.

A relative told us, "[Person] gets a double choice at meal times and the cooks are quite good and they try and get the healthy stuff in". Staff were aware of people's food and drink preferences and people were supported to make choices at mealtimes. A member of staff told us, "[Person] loves it when we put [food item] on the menu". We saw people were weighed regularly and supported to maintain a healthy weight. People's food preferences were catered for and this included taking into account people's religious beliefs.

We saw that people's bedrooms were personalised. The provider told us they were embarking on a programme of redecoration for the communal areas in the home. We noted there was a lack of signage around the home to assist people when navigating to different areas.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed how the registered manager had ensured people's freedom was not restricted.

We noted that a number of DoLS applications had been submitted to and authorised by the local authority. We saw in people's care records that some decisions had been made in people's best interests, but there was no evidence to demonstrate people, their relatives or advocates had been involved in the decision making process. Not all best interests decisions taken had been recorded. For example, we found for four people listening devices had been placed in their rooms for their safety, but no best interests meetings or decisions had been recorded regarding this. We raised this with the registered manager who told us they would rectify this promptly. Staff spoken with had received training in this subject, but some staff required prompting when asked what this meant for people living in the home.

We could not be confident that people were consistently supported to make choices regarding their daily living. We were told, and we noted many recordings in care records where people had refused to leave the building for a walk or an activity and in response to this staff had restrained the person and then ensured they left the building, despite them demonstrating they did not want to leave. We saw no evidence of best interests meeting advising that this activity and response to these behaviours had been agreed as in the person's best interests.

This was a breach of Regulation 11, Consent, of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014

One relative told us, "I think the support is of good quality; it's very difficult sometimes, [person] is very challenging" and another said, "I think it's ever so good [the care]. They [staff] always know what they are doing, we are very happy with the service [person] gets". We noted that people's care records provided staff with detailed information about them, for example, their relationships with friends and family, activities they enjoyed and didn't enjoy and their preferences when it came to food and drink. Care plans also noted whether people preferred male or female carers. Care plans stated, 'I need my carers to understand my cultural differences and family traditions' but in some files seen, this information was not made available to staff.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in December 2016, the provider was rated 'Good' in the question 'is the service caring?' Following this inspection we have changed the rating to 'requires improvement' based on our inspection findings.

Communication systems in place were not effective in supporting people to express their views and be actively involved in making decisions about their care. We saw that communication care plans in place provided staff with information how to communicate effectively with people, for example by observing body language and using picture cards. We were told that one person used Makaton to communicate and their communication care plan stated, 'staff to encourage me to sign what I want, ' but we found that staff had not received training in this. A member of staff commented that this person must be frustrated as staff found it difficult to understand what they were trying to tell them. We also spoke with a relative who told us they were not sure if staff were using picture cards to communicate with their loved one, but would raise this with the registered manager.

From our conversations with many staff, it was clear that they cared for the people they supported. We observed staff interact pleasantly with people, for example when talking about plans for the day, or offering choices at mealtimes. Staff knew people well and what was important to them. For example, we saw that one person was attached to particular objects which they liked to carry around with them. Staff spoken with were aware of the importance of these items and ensured the person had them to hand. The person's relative also confirmed how important these objects were and how they helped their loved one remain calm. However, they also expressed concern that on occasion, not all staff were aware of the importance of these items and that they had noted their loved one had been told to leave them in their bedroom whilst they laid the table. The relative told us, "Our number one priority is that [person] is happy and comfortable first and any skills learnt [such as laying the table] can be built on that" adding, "Staff are kind and treat [person] with dignity and respect, but the issue with the objects is part of this. Staff need to respect this is important too".

Relatives spoke positively about the kind and caring nature of staff and we received the following comments; "They [care staff] really care about [person] and are very fond of them", "[Person] is exceptionally fond of [named two members of care staff] and they understand [person] beautifully" and "The staff are very kind and caring and do the best they can. [Person] can be very challenging". Two relatives commented that their loved ones were able to tell them when they wanted to return to the home [following family visits] and that this in itself gave them peace of mind that their loved one was happy to return to the home. One relative said, "When [person] returns to the home, they are happy to go back 95% of the time. We know if everything is nice in their world, then they are ok".

Relatives told us they considered their loved ones to be treated with dignity and respect. Staff were able to describe how they respected people's privacy and a member of staff told us, "They [people] are treated with respect, I think so, you always close their bathroom door and you always give space if they want personal time".

We saw information on display on how to access advocacy services and the registered manager had an understanding of when advocacy services would be required and how to access them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2016, the provider was rated 'Good' in the question 'is the service responsive?' Following this inspection we have changed the rating to 'requires improvement' based on our inspection findings.

We asked relatives if they felt their loved one had a choice in whether to go out or not to pursue activities that were of interest to them. One relative said, "I would assume that [person] has some choice in what they do, but I can't say so for sure". We were told it was in people's best interests to go out but we found no record of meetings where it was discussed and decided, for example, that a person needed to go out on a walk three times a day, even if they refused to go out. A relative described how their loved one had been ill but had still been taken out for a walk. They told us, "I have bought this up with [registered manager's name] about when [person] was unwell. It seems like if it's on the list [to do] then they have to go out. Whereas I think they needed more time to recover if they were ill. If they don't want to go out we need to believe in them". Another relative commented, "They [people living at the home] all seem to go out and they have to go out and get their exercise. I would like more things [for them] to do in the house". However, despite these concerns, relatives spoke positively about the variety of activities their loved ones were supported to take part in. One relative said, "[Person] gets taken out all the time, they go to the shops, theme parks, swimming, they have a better social life than I have!" and another relative said, "Everyone goes out every day; swimming, cinema, into Birmingham sometimes, they all get out and about". We saw another person who enjoyed gardening was supported to follow this interest through a work placement at a local trust and their relative spoke positively about this and the impact this had on the person. They told us, "It works really well for [person], lots of outside activity".

Each person had their own daily activity planner that was in a pictorial format, making it easier for people to understand. We were told the planner was put together based on the information available regarding activities people enjoyed taking part in. There was a culture of people being supported to access the community several times a day and we observed this during the inspection.

Relatives told us they were involved in pre-assessment and transition process and one relative commented, "We had an extensive discussion; they were our preferred provider. It was a good transition, it was really well done". We noted that people's care records held personalised information about them, such as their likes and dislikes, healthcare needs and social activities. Care plans described people, what upset them, what they enjoyed and how to interpret different behaviours they may present. Staff spoken with were able to provide a good account of people, the risks to them, what was important to them such as routine and family relationships. We saw that although care plans were detailed, they were repetitive and lacked consistency across the files. For example, for some people, information was available to people in an easy read format, but was not provided in others.

We saw that the registered manager invited relatives and healthcare professionals to six monthly reviews to assess people's care needs. One relative told us, "I'm not able to attend reviews, but I get a print out of information" and another said, "I listen to what is being said and they do ask me some questions and keep

me informed". We saw that healthcare professionals had been invited to reviews but had not always attended and a social worker told us, "In all fairness, they [the provider] hold reviews, but people don't come". Relatives spoke positively about the reviews and the information that was presented to them. One relative told us, "I have been absolutely involved in everything. They are outstanding".

We noted people were supported to maintain their relationships with their loved ones including visiting relatives on a regular basis. One relative told us, "I visit every two weeks, I always make sure he is there when I visit".

One relative told us, "I've never had any cause for concern" and another said, "I've never raised a complaint, I'm assuming you would contact the manager". Relatives told us if they had any concerns they were confident they would be dealt with. We saw the last complaint received was in April 2016 and was logged in the complaints book and made reference to concerns raised regarding a member of staff raising their voice to a person living at the service. The log referred to disciplinary procedures being followed and retraining being provided to the member of staff, however, there was no evidence available to confirm that this had been done or a record to confirm that safeguarding concern had been raised.

Inadequate

Is the service well-led?

Our findings

At our last inspection in December 2016, the provider was rated 'Good' in the question 'is the service Well Led?' Following this inspection we have changed the rating to 'Inadequate' based on our inspection findings.

People at the home were not protected and supported to be safe as the registered manager and the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were inadequate auditing systems in place to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home.

Accidents and incidents were inconsistently recorded and there was no auditing of these records to ensure the appropriate actions were taken and lessons were learnt. Safeguarding concerns were not routinely identified, investigated and reported to the appropriate authorities. The staff training matrix identified that five staff had not received training in autism, an area the service identified as their specialism. The registered manager had failed to identify this shortfall in training need. Further, staff competencies were not assessed to ensure staff were supporting people safely and effectively and in line with training that was provided. We found staff were not following their own policy and procedure when it came to reporting and recording incidents of behaviour that challenged. People's care records were inconsistently recorded. Daily records were not consistently completed or signed. Where incidents were recorded there were was no note of actions taken or incidents acted upon. It was not always clear who had completed paperwork and when, as signatures and dates were missing from documentation. We saw health action plans were not fully completed and not all staff had signed to say they had read and understood people's care records. The registered manager had no audits in place to recognise and act on these shortcomings. Meetings and conversations with other professionals were not routinely recorded, making it difficult to evidence that decisions had been made.

We found that MAPA was being used to force people to go outdoors and despite the registered manager telling us they did not agree with this practice, they had failed to take action to prevent it from happening.

We spoke with a representative from the company that trained staff in MAPA. They told us they had looked at people's restraint management plans and concluded they did not provide staff with enough detail and there was no information that detailed what lead to the behaviour. This meant that staff were not equipped with the knowledge required to keep people safe and reduce the need for MAPA techniques to be used as the information on how to do this was not available.

There was a lack of good governance and oversight in the monitoring of medicines management. Audits in place were ineffective and did not highlight the areas identified during the inspection. The registered manager told us they had been made aware of the NICE Guidelines following a visit from a pharmacy inspector. They told us the pharmacist had advised them to have photos taken and placed on people's MAR [Medication Administration Records] to ensure medication was administered to the correct person. We saw

that the photos had been taken, but the registered manager had failed to write the name of the person against the photograph. It was of concern that the registered manager had not identified the potential risk of medication being administered to the wrong person as a photograph alone should not be relied upon to identify the person who received the medication.

We asked the provider how often they completed their own audits of the service, they told us, "Not enough". We saw the last audit had been completed in January 2018. We were told they should be completed monthly, but could only find evidence of one provider audit being completed in February 2017. The last infection control audit was dated 2016.

A member of staff said, "[Registered manager's name] never goes round the building, they don't know what is going on and is just being told what is happening and they are usually biased". We asked the registered manager the reason for the decline in their oversight of the service. They told us that last year they had been involved in supporting a sister service and had put too much reliance on a particular member of staff to carry out audits. They confirmed that they did not check that the member of staff was completing the audits or ask for any feedback or monthly reports. They told us, "[Staff name] is supposed to do a manager's report to me, but I'm still devising the form". We were told another member of staff was responsible for sending through notifications of events to the Care Quality Commission, but found no evidence of this and the registered manager confirmed they had failed to check that this was done.

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

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager was not fully aware of their responsibilities to inform the Care Quality Commission of notifiable incidents at the service. They told us that another member of staff was responsible for sending through notifications to Commissioning, but not to CQC [as is required by law] and we had not received notifications for a number of incidents that came to light during the inspection. We shared with the registered manager, the guidance available to them on the CQC regarding provider's responsibilities to notify us of particular events, such as serious injuries and allegations of abuse. The registered manager told us, "I will print it off and read it and once it's in my head, it's in".

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

Staff told us they were concerned regarding the number of social workers and other professionals visiting the service [following the safeguarding concern] and said the registered manager had failed to inform them of the reasons why. They told us the lack of information had had an impact on staff morale. One member of staff told us, "We've not been told what has happened; not had any kind of information or reassurance. I understand [registered manager's name] is very stressed, it's a difficult job, but we are the backbone of this house" and another member of staff said, Staff are concerned, but have pulled together". We saw that an internal memo dated 07 March 2018, had been placed in the main office advising staff that a safeguarding investigation was taking place, but was told no meeting had taken place.

Relatives were complimentary of the service and told us they felt it was well led. They spoke highly of the registered manager and told us they were approachable. We received the following comments, "I have completed surveys. Never had any cause to raise concerns. [Registered manager's name] is my point of contact and I have her mobile number", "I speak to [registered manager's name], and always give her a kiss when I see her, she's like part of the family" and
"[Registered manager's name] is on the phone fairly often to us. They do a fabulous job but do worry now

and then when [person] becomes more anxious and you pick up on these things. Appreciate the good work they do and generally quite happy with the service" and "If we had any major concerns we would have had him moved out of there".

We saw surveys had been sent out to relatives and professionals in January 2018. The feedback received from relatives was positive, for example, "Highly valued care and support provided to our son to enable him to live a safe and happy life".

One member of staff told us, "If you go to [registered manager's name] with a problem, they will find a solution". Other staff were equally as complimentary about the registered manager and found her to be supportive and approachable. Staff told us they were aware of the provider's whistle-blowing policy. We saw staff meetings took place to provide staff with the opportunity to raise concerns. One member of staff told us they didn't feel listened to and said, "When I do raise things, I feel I am ignored". They provided us with an example of an incident they had raised which they felt was not followed up appropriately, adding, "I don't want to push things too much as it makes my life harder". Other staff spoken with told us they felt listened to by the registered manager and felt that if they did raise a concern it would be responded to.

We asked the registered manager how they kept up to date with the latest guidance in order to continuously learn and develop the service. They told us they were signed up to the CQC website and received the monthly provider emails. However, they were not aware of the changes that came into place in November 2017 regarding the areas looked at during inspection or other areas of guidance for providers such as 'registering the right support' or the 'accessible information standard'.

We saw the provider had on display the previous Care Quality Commission rating of the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of incidents that affect the health, safety and welfare of people who use the service.

The enforcement action we took:

Issue NOP to impose conditions. Provider to send through monthly report on action taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that staff consistently obtained people's consent before any care or treatment was provided.

The enforcement action we took:

Issue NOP to impose conditions. Provider to send through monthly reports highlighting actions taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure relevant health and safety concerns were included in people's care and treatment plans and that medical attention was consistently sought when people were unwell.

The enforcement action we took:

Issue NOP to impose conditions. Provider to send through monthly report on action taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure service users were protected from abuse and improper treatment in accordance with this regulation.

The enforcement action we took:

Issue NOP to impose conditions. Provider to send through monthly report on action taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home.

The enforcement action we took:

Issue NOP to impose conditions. Provider to send through monthly report on action taken.