Enigma Care Limited

Little Acorns

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We carried out an unannounced comprehensive inspection of this service in March 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider is required to send us an action plan to show how they intend to improve the service and meet the identified breaches. We had not received this action plan until after the completion of this focussed inspection completed in July 2015.

This report only covers our findings in relation to those requirements we were reviewing from the previous inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

This inspection took place on the 8, 9 23 July and 25 August 2015 and was unannounced.

We wanted to check on any improvements made following our last inspection carried out in March 2015 where we found a number of breaches. These breaches were under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Since April 2015 we have been operating under new regulations, the

Summary of findings

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 so for the purposes of clarity we have mapped the old 2010 regulations with the new 2014 regulations within the main body of the report.

Little Acorns is registered to provide accommodation with personal care for up to 11 people who have autism. Little Acorns is also registered to provide a personal care service to people who live in their own homes in the community. At the time of this inspection there were nine people living permanently in Little Acorns and there were also three people who regularly stayed there for shorter periods of respite care. Three people who shared a house received a personal care service, plus one person who had respite care at this service. One older person who lived in their own home received personal care visits from care staff five times a day.

The Nominated individual is also the registered manager of the service. Since our inspection of the service on 20 August 2014 the registered manager had ceased to provide day to day management of the service. When we inspected the home in February and March 2015, there was an acting manager who had been appointed. Currently the nominated individual remains legally responsible as the registered manager for the day to day management of the service. 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.

In March 2015 we found that people were at risk of receiving inappropriate and unsafe care. The delivery of care did not meet people's individual needs or ensure their safety and well-being. People's needs and risks had not been fully assessed or translated into care plans to address their needs and risks. There were not always enough staff to ensure people's safety and well-being.

Concerns found during this inspection were so great that the service was, and continues to be, subject to a multi-agency safeguarding process. As part of that process, a multi-agency safeguarding protection plan was agreed with the provider, CQC, police and health and social care professionals to protect people's safety and well-being. This process included health professionals visiting the home regularly as part of the support plan and in a protection role. There has also been further information of concern which is currently being followed up via the safeguarding processes.

We also found the quality of the service was poor because of a lack of governance systems. Insufficient actions had been taken to identify areas of poor service or to take actions to address them. Effective systems were not in place to monitor and assess the quality of provision. The systems to record, investigate and respond to incidents, accidents and complaints were poor. Medicines and access to medicines when needed was poorly managed.

There was a lack of respect shown by some staff when talking to people about personal matters. There was a lack of respect shown in the daily notes made by staff. People were restricted by rules and regulations which had not been agreed with them and there was no evidence these had been set up in people's best interests.

Where people were subject to a number of restrictions and rules which they had not agreed to, there were no risk assessments, no best interest assessments and no Deprivation of Liberty Safeguards (DoLS) authorisations.

People's views were not actively sought about the service and there were no systems in place to encourage people to raise concerns or complaints. People were not actively supported to raise complaints.

People's records were not kept securely to maintain confidentiality. Records were not always accurate and some were poorly maintained.

During this most recent inspection completed in July and August 2015, there was still evidence that people were at risk of receiving inappropriate and unsafe care at Little Acorns. There were insufficient numbers of staff to meet people's needs. Staff were expected to carry out duties away from Little Acorns, which meant they could not provide care to people. These duties included providing personal care to people at another location and a morning and afternoon chauffeur service for people attending day services at the home.

We found some improvements in the way people who received personal care in their own home were being supported. One person confirmed they had been involved in the development of their own care plan and

Summary of findings

others were able to describe how they were being supported to follow up on their aspirations for work and social activities as part of the care and support they had received. We had received some information of concern which suggested that one person receiving personal care was not getting what they needed. We found there were times this person had not received all of the visits which had been agreed. We also found staff who were allocated to work with people at Little Acorns were covering some of the visits to this person. This meant that managers were having to make a decision whether to reduce the number of staff who supported people at Little Acorns at times or the person missed a visit.

Some action had been taken to address the concerns which related to fire safety within the building but some other concerns regarding handrails on the swimming pool and the kitchen used by service users for activities had still not been addressed.

During this inspection, we observed some staff practices which showed there was still a lack of respect and dignity shown to people on occasions, although we also observed some staff showing a caring and positive approach towards people. There was evidence provided from health and social care professionals that Little Acorns staff were still failing to follow guidance they provided. This meant some people were not receiving the care they should have had.

We found there were some improvements as medicines were no longer stored in the upstairs cupboard. However we found that the systems to record medicines administration were not always completed fully. Systems to monitor and audit medicines and prescribed creams were not robust.

Some work had begun on looking at people's care files and care plans and risk assessments. However, this was still work in progress and there were still gaps and lack of reviewing plans which meant staff did not always have accurate information on which to base their practice and how to support people. This placed people at risk of receiving inappropriate care and support as there were newer staff and agency staff who did not have the historical knowledge of how to work with people with complex needs.

Some improvements had been suggested to look at activities for people outside of the service, although these had yet to be put into effect. These included possible visits to a sensory park in Exeter and the use of an activities centre where they planned to look at boating, archery etc. No risk assessments had been undertaken to show the service had considered the risks associated with these types of activities. However there were still some people who had very rigid routines which had not been agreed as part of a best interest assessment. Staff were not following the support plans devised by healthcare professionals to enable them to have stimulating and enriched experiences. For example one person should have been doing sensory cookery sessions each day but this had only occurred once in a four week period. Another person was not supported to have regular opportunities to pursue their love of trains by undertaking a weekly individual train journey, although this had been recommended and had been agreed with the person concerned and staff at Little Acorns.

Where people had complex needs which had increased, there had been no analysis of these behaviours, what the triggers may be or risk assessments in place to protect the person and staff. For example one person had increased anxiety in the early morning period. There was one waking night person available during this time and there was no clear guidance as to how best to support this person through their anxiety.

Another person had increased challenging behaviour when out. There was no analysis of what may be causing this. There had been a recent incident where the person sustained bruising due to having to be supported to move to a safe place by two staff. Following this there had been no change to their support/care plan. On the first day of the inspection staff said this person was out on a trip with people, not employed by the service, who had known and worked with the person some years previously. There had been no risk assessment around this trip or any evidence that the people who took the person out had been made aware of changes in the way the person acted or behaved in recent times. Staff from Little Acorns had not accompanied the person on the trip which meant the person and the accompanying people were at risk of an incident which would not be managed according to the latest information available.

Although staffing levels had increased, newer staff did not always have a full induction or enough time to be fully supported before they were expected to be part of the

Summary of findings

staff team supporting people. We found two waking night staff who were inexperienced, had only received a very brief induction and had only shadowed one other shift before they were left to work independently. This placed staff and people at risk because new staff did not have the skills and training to understand the needs of people they were working with. One member of staff had been threatened and on some shifts, hit by a person who had woken early and been distressed. The member of staff said they had lost confidence in working at night.

There were not always enough staff available in sufficient numbers and with the right skills to meet people's needs and ensure people's safety and well-being. Staff were being used from the staffing levels from Little Acorns to cover transporting day care and respite people and to cover domiciliary hours for people living in their own homes in the community.

Recruitment was not robust, newer staff had started before all the checks to ensure they were suitable were in place. One newer staff member had given a very brief employment history and this was not followed up. References were received after the date of new staff commencing work, without any other checks to ensure their suitability to work with vulnerable people being in place..

Records relating to people's finances had improved with receipts being kept and numbered. However there were still areas where people's monies were unaccounted for. The registered manager agreed to obtain an independent audit of people's finances and make a safeguarding alert.

There were recorded incidents of people needing to be restrained to prevent injury to themselves of others, but not all staff had received training in how to do this safely.

One person was at risk of choking as staff had not read their risk assessment relating to this risk had had been seen assisting them to eat food which presented a risk by a healthcare professional.

We found there had been some improvement that complaints were now dealt with effectively. For example we saw a senior member of staff had acknowledged a concern made by a family and had responded to this appropriately. However another relative said they had not received a response to a request to make a complaint.

Some staff showed a caring and positive attitude to people when working with them. However we also observed some less caring approaches by some staff.

There was a lack of management leadership and lack of systems to check on the quality of care, which meant people were at risk of receiving care which was not appropriate to their assessed needs and did not follow best practice. There was no evidence of audits being completed to ensure the right staff with the right skills were being employed, supported and trained to do their job.

During the inspection, we identified a number of serious concerns about the care, safety and welfare of people who received care from the provider. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In October we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Since the original inspection on 28 February, health and social care professionals have been involved as commissioners, or in their safeguarding role, to ensure people's safety and welfare was monitored. During this time, they arranged for people who were using this service to move to alternative provision

Summary of findings

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.

There were not sufficient numbers of qualified and competent staff available to ensure the safety of people and staff.

Recruitment was not robust and did not therefore fully protect people.

Senior staff had not always reported serious incidents to the right external bodies so people were not safeguarded.

Risks had not been fully assessed and therefore people could not be assured their safety and well-being was always fully considered.

Is the service effective?

Inadequate

The service was not effective.

Staff did not understand the principle of working within the Mental Capacity Act, or working in the least restrictive way to enable people choice.

Induction, training, supervision and appraisals did not provide staff with the right skills to do their job safely and effectively.

Restraint was being used in some situations without staff having received the right training and support to do this effectively.

People were at risk of choking because some staff were not aware of the risks when assisting people and inappropriate food was being offered placing one person at risk.

People were positive about the meals and choices being offered

Is the service caring?

Requires improvement

Whilst some aspects of staff working with people showed a caring attitude, there were examples of where staff did not always adopt a caring approach.

Staff did not understand how to work in the least restrictive way and were therefore not always showing respect for people's diversity.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not appropriately assessed and changes to their risk assessments and care plans had not been completed.

Risk assessments and care plans were not individualised or personal.

People were not involved in the development of their care plan and therefore their wishes and aspirations had not been taken into account.

Summary of findings

Complaints were not consistently and robustly investigated and resolved.

Is the service well-led?

Inadequate

The service was not well-led.

There had been a significant number of changes to senior staff. New senior staff were not supported to take on their role effectively.

Statutory notifications of significant events had not been submitted to the Care Quality Commission.

There was a lack of management leadership and lack of systems to check on the quality of care, which meant people were at risk of receiving care which was not appropriate to their assessed needs and did not follow best practice.

There was no evidence of audits being completed to ensure the right staff with the right skills were being employed, supported and trained to do their job.

Little Acorns

Detailed findings

Background to this inspection

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

This inspection took place on 8, 9, 23 July and 25 August 2015 and was unannounced. The inspection team consisted of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for people with autism.

During this inspection we looked at four care plans and daily records, medicine administration records, records relating to people's finances, three recruitment files, training records and records relating to quality assurance processes. This included staff meeting minutes, and minutes relating to a meeting held with relatives.

We spent time talking with seven people who used the service and with 13 staff. Following the inspection we spoke with two relatives and with seven health and social care professionals to gain their views on any improvements following the last inspection.

Inadequate

Is the service safe?

Our findings

Our inspection in March 2015 found a breach of Regulation 21 of the 2010 regulations (Requirements relating to Workers) which is now covered by Regulation 19 of the 2014 regulations (Staffing). People were not protected against the risk of unsuitable or unfit staff working in the service. Incidents and concerns about staff had not been investigated, and disciplinary proceedings had not been carried out. There was no evidence to show senior staff had considered any actions to address poor practice.

Recruitment files of staff employed since our last inspection showed the process was not robust. For example three staff files showed their start date was before the dates of receiving any satisfactory information to show new staff were suitable to work in this service. One application form did not contain a full employment history and there was no evidence that this had been explored further with the staff member. One new staff member had been in a number of care roles but only gave personal references. The previous care industry employers had not been contacted for information. One recruitment file for a new staff member showed they had started their employment on a date before any Disclosure and Barring check had been completed.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulations 2014).

Our inspection in March 2015 found a breach of Regulation 22 of the 2010 regulations (Staffing) which is now covered by Regulation 18 of the 2014 regulations (Staffing). There were not always sufficient staff to support people safely. We also found that there were no waking night staff on duty although this had been commissioned by the local authority.

At this inspection we found there was still not always sufficient staff to cover the assessed needs and agreed commissioned hours for people. This was because there were times when staff were rostered to work at Little Acorns, but were being expected to cover some hours of a personal care contract for the domiciliary care service. This meant that up to four times per day, a member of staff would leave Little Acorns for up to one and a half hours to provide care elsewhere. There were also times during the morning and afternoon where a member of staff who was rostered to provide care to people at Little Acorns picked up or dropped off people who were receiving day care at Little Acorns but who lived up to 30 miles away. This meant that staff were off site for around two to three hours each morning and each afternoon. The staffing rota indicated there were eight staff on a shift, however these additional offsite duties meant two staff were not providing the care to the people at Little Acorns. Consequently some of the people who were funded and assessed as needing one to one support were not receiving this care. We discussed this with senior staff, who said they were aware of these issues and had discussed their concerns with the registered manager.

A senior member of staff said there was only one member of staff awake on duty at night together with two staff sleeping on the premises. They said they had been told by the registered manager that this was the level of staffing commissioned by the local authority. We contacted the local authority after the second day of inspection to check what staffing levels they commissioned for people at Little Acorns. They confirmed they expected two waking staff and one sleeping member of staff on duty at night. Following a meeting with Devon Local Authority who commissioned care for a number of people at Little Acorns the provider was told that they had to ensure that there were two waking staff and one sleep in member of staff on duty from the night following the meeting.

We were also concerned about the level of support and induction for newer staff. The rota showed there were periods where new staff were included as part of the overall staffing levels when they had only been working for a short time. For example, one member of staff described how they had been expected to work a waking night shift on their own and had not felt confident or safe in doing so. They also described how they had been injured whilst on a night shift by a person at the home. Due to staff leaving, agency staff were being used for some shifts on most days and sometimes there were up to three or four agency staff per shift. This combination of newer inexperienced staff, agency staff and more experienced staff having to take on duties outside of their work at Little Acorns, meant there was not enough staff with the right skills and experience to ensure the safety and quality of care of people.

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

Our inspection in March 2015 found a breach of Regulation 9 of the 2010 regulations (Care and welfare) part of which is

Is the service safe?

now covered by Regulation 12 of the 2014 regulations (Safe care and Treatment) The inspection showed people were at risk of receiving inappropriate and unsafe care. The delivery of care did not meet people's individual needs or ensure their safety and well-being. People's risks had not been fully assessed or translated into care plans to address their needs and risks. At this inspection we found there were no improvements in risk assessments and care plans for people living at Little Acorns. There was no evidence of how risks had been translated into people's care plans for staff to understand how they should deliver care. For example in one person's plan there was a stool chart which had not been completed for six consecutive days and five consecutive days in one month. There was no instruction within the care plan as to what staff should do if the person remained constipated. Staff later showed us the person's home communication book which showed staff had recorded when the person had had a bowel movement which was usually daily or every other day. We were also later shown a memo within the medicines folder which described what staff should do if the person went more than three days without a bowel movement. Since newer staff were not allowed to administer medicines, they may not have been made aware of this information. We discussed this with senior staff at Little Acorns, who said they had not had time to update the risk assessments and care plans for people living at Little Acorns as they were often having to work for much of their time in a care worker role because of staff shortages.

There was also evidence that one person who was supposed to have one to one care at all times at times went out with one member of staff who would be driving to either pick up or drop off people who were using the day services at Little Acorns. The staff member who drove was not accompanied by any other staff in the vehicle. This meant that the person who was supposed to have one to one care was not receiving this as there were other people who used the service in the car but no other staff. As the staff member was also driving, it would not have been possible for them to give their full attention to the care and support of any of the people in the car. This meant that risks were not being managed well. This was discussed at a meeting of senior staff with Devon local Authority representatives who said that in future the person was not to go out on these journeys unless supported by a member of staff who was not driving.

Another person had been having incidents where they were displaying distress when out with care staff. This person's risk assessment had not been updated. On the first day of the inspection the person went with people they knew from a previous placement who were not employed by Enigma Care. There had been no risk assessment for this trip out, or any consideration given to supporting the outing by sending a member of staff who worked with the person at Little Acorns. This put the person and the people taking them out, at risk.

We also found that risks relating to a particular person had not been recorded as part of a risk assessment. For example we reviewed one person's file which showed that risk assessments had last been reviewed in February 2015 prior to the last inspection. Although there was evidence in the daily notes of particular behaviour, there was no risk assessment relating to this or any care plan to describe how staff could help the person with this. This meant that staff were not fully informed about how to support people with all their needs. Given that there had been significant changes in staff and a high use of agency staff on most days, new staff would not have all the information they required to support the person

One person had been spending increasing amounts of time attending to their personal care, to the point this was impacting on their ability to engage in any activities. Their care plan and risk assessment had not been altered to reflect this change in their behaviour and mental wellbeing. This person was anxious and was refusing to go out. No analysis had been done to look at how the delivery of the person's care plan could be adapted to better support them through this distressing time for them.

One healthcare professional said they had witnessed a new member of staff helping one person at breakfast. ''She informed me that a resident had prepared x breakfast and x was given large prunes that were not cut up or mashed and the member of staff had not read or seen the policy for x regarding choking or preparing her meals.'' This placed the person at risk of choking and was in not in line with guidance and best practice.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

Inadequate

Is the service safe?

We did find that risk assessments and care plans had been updated for most of the people who received personal care in their own homes in the community. We discussed the changes that had been made with a senior care worker, who said they were now using revised forms to record risks.

Our inspection in March 2015 found a breach of Regulation 13 of the 2010 regulations (Management of Medicines) which is now covered by Regulation 12 of the 2014 regulations (Safe care and treatment). Medicines were not administered safely and there were not effective systems to ensure that stocks of medicines were audited effectively.

During this inspection, there were still concerns identified relating to the systems to record the administration and stock controls of medicines. There were not effective audits of medicines received and administered. A senior member of staff said they were unable to explain why the number of tablets recorded on a Medicine Administration Record Sheet (MARS) did not tally with the number of tablets in the medicines cupboard. There were also two tubes of the same cream that had been opened for one person. Neither tube had any information recorded as to when it had been opened, which meant that it could have passed their usage date. Another person's MARS stated that a person should be given one or two tablets for hay-fever each day, but there was no information as to when one or when two tablets should be administered in the MARS. The person had been administered two tablets each day. We discussed this with a senior member of staff who said they were not sure and did not think it was recorded in their care plan. The home's procedure was that two staff would sign for any medicines administered. However in one MARS, on seven days in July only one member of staff had signed medicine records.

We looked at the controlled drugs records for one person and found that there was a discrepancy in recording. A controlled drug is any drug or therapeutic agent, commonly understood to include narcotics, with a potential for abuse or addiction, which is held under strict governmental control, as delineated by the Comprehensive Drug Abuse Prevention & Control Act passed in 1970.

On one occasion in August the remaining number of drugs had been reduced by one more than had been administered although there was no evidence that the tablet had been accounted for as either lost or disposed of.

We also found that on one occasion there was no signatures to record who had administered the controlled drug which meant that staff were not following the correct procedure.

There was no evidence of any audit processes that had identified the discrepancy or the lack of signature any action taken to investigate the issue. Subsequent to our visit we were informed by the registered manager that the concerns were being investigated and that they would provide a copy of the report from the investigation.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

Our inspection in March 2015 found a breach of Regulation 11 of the 2010 regulations (Safeguarding people who use services from abuse) which is now covered by Regulation 13 of the 2014 regulations (Safeguarding service users from abuse and improper treatment). The concerns related to people being at risk of financial abuse because the provider had not implemented systems to ensure that people's money was protected.

At this inspection we found people were still at risk of financial abuse as there were inadequate systems in place to protect them and their finances. For example, we found evidence that one person had withdrawn large sums of cash from their bank account, but there were no documents to provide evidence of how this money had been spent or whether the person still had it. There had been no risk assessment or capacity assessment to show whether this person was able to manage their own finances. However a senior staff member said this person would be unlikely to understand or manage large amounts of money, which was why the service held the records relating to this person's bank accounts. This had been noted prior to our inspection visit by management, but they had not reported this and neither had they completed any other audits of other people's finances, to check if there were any further inconsistencies.

During this inspection, an incident of one person hitting another person had been recorded in the incident log. However, we found no evidence that staff had taken appropriate action to reduce the risk of this happening again. Staff confirmed there had been no new risk assessment or change in procedure of how they worked with this person subsequent to this incident. The incident

Inadequate

Is the service safe?

had not been reported to the local authority safeguarding team as it should have been. This meant there had been no independent investigation or review of this incident, to ensure this person and others were protected.

In August 2015, we received information of concern relating to the care of one person which resulted in a safeguarding incident. The issue was discussed with staff from the local authority who undertook a visit to investigate the circumstances of the instance. Following the incident, two inspectors undertook a further monitoring visit on 26 August 2015 at 19.30 hours to gather information about what systems had been put in place to reduce the risk of a similar incident recurring. We found that there were systems in place now to monitor people at night on an hourly basis and that there was evidence that these had been carried out by staff on the night prior to our visit. There will be a safeguarding meeting to consider the information surrounding this serious incident.

One staff member said they had raised concerns in June 2015 about the attitude and conduct of two members of staff. When we checked the records concerning this, we found the nature of the concerns should have been shared with the local safeguarding team. Instead the management team at Little Acorns held their own internal disciplinary processes in respect of one member of staff. No actions were recorded about the concerns regarding the second member of staff.

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

Inadequate

Is the service effective?

Our findings

Our inspection in March 2015 found a breach of Regulation 23 of the 2010 regulations (Supporting Staff) which is now covered by Regulation 18 of the 2014 regulations (Staffing). Our inspection showed people were not protected as staff had not received the necessary training and support to enable them to do their job effectively. Staff did not receive regular supervision and appraisal. Staff employment files did not consistently contain evidence of induction training that met with national good practice guidelines. Two newer staff said their induction had been brief and did not cover all aspects of working in care. There were gaps in training records and over half the staff had not undertaken most courses.

During this inspection, we found that some training for staff had been completed. Whilst there was evidence that staff supervisions had been planned and some staff had received these, not all senior staff had been trained to provide this level of support to staff. One senior member of staff who had been given responsibility to supervise more junior staff said they had not received training in understanding the principles of supervision and supporting staff.

Managers showed us they had obtained files for new staff to complete the Care Certificate but were unaware of the need for new staff to be signed off in specific areas before they were able to work unsupervised. We found examples where new staff had been employed to work waking nights alone, with sleep in staff as back up. There was no documented evidence that these staff had received an induction in working nights with people with complex needs, or been able to work alongside more experienced staff to enable them to fully understand the role. One newer inexperienced staff member confirmed they had completed one shadow shift with another member of staff and then was rostered to work waking night shifts without support. The member of staff said they had not felt safe at times as some people in the home had challenging behaviour which the staff members said they did not feel able to deal with. This placed people and staff at risk.

Some training had been undertaken by staff. This included training about the Mental Capacity Act (MCA) 2005. Most staff had also completed some awareness training in working with people with complex needs and dealing with situations where people may need support to calm down.

We asked if this included any safe holding as there were occasions where this type of restraint may be required. We were told this had not been covered as the home's policy was for no restraint. However two recent incidents reported to CQC showed that staff had used restraint to either protect themselves or protect the person from harm. We asked for the service's policy on restraint but did not receive this. There had been a recent incident where the person sustained bruising due to having to be supported to move to a safe place by two staff. Following this there had been no change to their support/care plan.

Some staff had received training in defusing challenging behaviour but not all staff had received this and two staff members confirmed there were times they needed to release themselves from a hold from people, but had not received training in how to do this in the safest way.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulations 2014)

Our inspection in March 2015 found a breach of Regulation 18 of the 2010 regulations (Consent to care and treatment) which is now covered by Regulation 11 of the 2014 regulations (Need for consent). We found people were subject to a number of restrictions and rules which they had not agreed to and for which there were no risk assessments, no best interest assessments and no Deprivation of Liberty Safeguards (DoLS) authorisations, although four applications had been made. However consideration for applying for DoLS had not been considered for other people who were subject to restrictions. These included removal of personal items at night, monitoring devices being used at night, people being told what time they had to go to bed, people being told what they could wear during certain times of the day and people being told where they were not allowed to eat and drink. People were also not able to access parts of the home during the night.

During this inspection, we found evidence that on occasions there were still restrictive practices being carried out which had not been agreed as part of a best interest assessment or DoLS application.

We found that there were DoLS authorisations for some people in place. However, staff did not understand how Deprivation of Liberty Safeguards (DoLS) worked in practice to ensure people's rights were protected and that they worked in the least restrictive way. We spoke with three

Is the service effective?

staff who worked directly with people who were subject to DoLS and they were unaware of a DoLS authorisation being in place or what the implications were for how they supported people. For example one person was expected to complete chores before they had their first morning cigarette. Whilst it was agreed that it was important to monitor and limit the person's tobacco intake, there was nothing within the DoLS which indicated that cigarettes could be used as a reward or punishment.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulations 2014)

Although some training about capacity had taken place since the last inspection this had not been embedded into practice. For example one person had been drawing out large sums of money from their account and there was no consideration as to whether they had capacity to understand this. The person was in a vulnerable position, carrying large sums of money outside of the home. Some monies belonging to this person were unaccounted for and a senior member of staff said the person would not have been able to explain where this money had been spent. The person did not go out into the community without a member of staff accompanying them. Since noticing monies were unaccounted for, the person's capacity to understand their own finances had still not been assessed. Staff also lacked understanding about how to work with people in the least restrictive way.

It was also clear that whilst restrictions had been agreed as needed to protect people, there was no sense that staff worked together to look at the least restrictive measures. For example one person, who was showing increased agitation in the mornings, two newer staff had been directed to place themselves in the kitchen with their foot against the door, preventing the person accessing the kitchen. This left the person free to move to other parts of the home, until the person had calmed down, which could have put other people in the home at risk, but restricted them from coming into the kitchen. There were no written instructions detailing this or a best interest decision to decide how best to manage this behaviour. One staff member said they did not feel safe, as a newer female member of staff working with individuals with complex needs who at times could show aggression.

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

Our inspection in March 2015 found a breach of Regulation 24 of the 2010 regulations (Cooperating with other providers) which is now covered by Regulation 12 of the 2014 regulations (Safe care and treatment). There was evidence that Little Acorns staff did not follow guidance from professionals, implement the guidance in care plans and communicate them effectively when necessary.

During this inspection, there was evidence provided from health and social care professionals that Little Acorns staff were still failing to follow guidance they provided.

Two healthcare professionals said they had been providing support and guidance in respect of working with specific individuals but their advice and guidance had not been followed. One healthcare professional stated ''Despite numerous training and support to Little Acorns from a range of professionals, this organisation continues to show it does not have the capacity to lead and provide effective staff direction in reinforcing that training to ensure best practice and to ultimately be responsive to people's needs . Too many staff are leaving and there is a total lack of coordination and staff cohesion around implementing appropriate daily individualised programmes; often at odds with recommendations we make.''

One healthcare professional raised concerns about the service not having the right adaptations available for people to meet their assessed needs. They said ''On carrying out numerous bathing assessments, Little Acorns is still resistant to adapting the bathroom and are continually compromising on what I have recommended.''

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

We heard how the service had adapted their practice to ensure people were given a choice around the meals being offered. People we were able to speak with said they got to choose what meals they would like. Staff said people each chose an evening meal on one day each week. If other people did not like this choice they were offered an alternative. One person said that if they did not like the meal they could have something else such as "something on toast". The weekly meal plan for evening meals in one of the two kitchens was on the fridge The meal plan was in pictorial form in the dining room.

Inadequate

Is the service effective?

One parent raised concerns about the fact their relative should have been more involved in menu planning and in being actively involved in preparing simple meals, which was not happening.

We observed one person, who said they were on a diet, being supported by a member of staff to prepare a calorie controlled lunch. The person said they were also supported to attend a weekly diet group to help them stay motivated to lose weight.

Requires improvement

Is the service caring?

Our findings

Our inspection in March 2015 found a breach of Regulation 17 of the 2010 regulations (Respecting and involving people who use the services) which is now covered by Regulation 10 of the 2014 regulations (Dignity and respect). Our observations and records showed there was a lack of respect shown by staff when talking to people about personal matters. There was a lack of respect shown in the daily notes made by staff. People were restricted by rules and regulations which had not been agreed with them and there was no evidence these had been set up in people's best interests.

During this inspection, we observed some staff practices which showed there was still a lack of respect and dignity shown to people on occasions. We observed a few examples of less caring attitudes by some staff. One person asked a staff member a question and was told to stop asking questions because the staff member was ''too busy" to deal with them.

When we were talking to one member of staff, the person they were with became agitated, displaying hand to mouth motions, rocking and making noises. We moved away saying it may be due to our presence. The member of staff did speak gently to the person reassuring them, but then said in front of the person "although he is complex some of it could be for attention". Another person was being asked by a staff member to speak with us and clearly did not wish to do so. The staff member was insistent until we said it was not necessary and the person moved away quickly.

There were details of restrictive regimes still being used, which did not show a caring attitude. One example was an entry in the communication book where a member of staff had highlighted that they had noted one person was in their en-suite after 10pm and suggested that the bathroom should be locked at night. We discussed this with a senior member of staff who said they had addressed the staff member who had written this comment as keeping the bathroom door locked would be restrictive. They agreed consideration needed to have been given as to why the person may need to use their en-suite at this time.

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

We observed some staff working with people in caring and respectful way, asking if they wanted to participate in an activity, talking about their day and having general banter about subjects the person enjoyed. One person for example, who had limited verbal communication, enjoyed physical contact and a staff member repeated words they said. They were happy to do this for around 10 minutes and clearly enjoyed the relationship they had developed with the staff member. We saw one person showing signs of distress and staff spoke to them in a gentle way, asking them if they were okay.

Most staff showed concern and care for people they were supporting. For example, one member of staff chatted with a person as they helped prepare a lunch for the person who was on a diet. We heard the member of staff, and another who was also present, complimenting the person on how well their diet was going and encouraging them to stick to the meal plans.

Another member of staff showed concern for a person who was appearing anxious, supporting them by offering reassurance. We also saw how they had encouraged the person to try out new experiences which the person was interested in doing.

One person living at Little Acorns said they thought care had improved at the home and they were supported to do more activities that they were interested in. Another person said they thought staff were "good" and helped them with aspects of their life.

Inadequate

Is the service responsive?

Our findings

Our inspection in March 2015 found a breach of Regulation 9 of the 2010 regulations (Care and welfare of people who use the services) which is now covered by Regulation 9 of the 2014 regulations (Person centred care). The inspection in March 2015 showed people were at risk of receiving inappropriate and unsafe care. The delivery of care did not meet people's individual needs or ensure their safety and well-being. People's needs had not been fully assessed or translated into care plans to address their needs and risks.

At this inspection we found there were no improvements in risk assessments and care plans for people living at Little Acorns. There was no evidence to show risks had been translated into people's care plans for staff to understand how they should deliver care.

There was no evidence to show that care plans and reviews had improved in order to enable staff to provide a dynamic and responsive service in Little Acorns. Where individual plans had been adapted to follow a professional's guidance, this was not always being followed. For example one person's plan had been reviewed to show they should be involved in sensory activities such as cooking. There was an entry in the staff communication book to inform staff this person should be helped to use the sensory kitchen each afternoon to bake cakes and bread. There was only one entry in the last month where this activity had been recorded. Most days this person was going on walks and playing with their toys in their room. Staff did not give a reason as to why sensory activities had not been planned for this person. This meant the person was not getting the sensory stimulation needed to help them be engaged in day to day activities

Our previous inspection found that many of the risk assessments were generic and not personalised to the individual. Risk assessments about specific concerns relating to an individual had not been developed. Care plans to address how to meet people's needs and address identified risks were not in place. During this inspection we found that many of the risk assessments remained generic and not person specific.

In the care record there was a review which had been completed in June 2014 by a social care professional, which described that the person wanted to reduce the number of cigarettes they smoked each day. However there was no mention in the care plan drawn up by staff at Little Acorns of this. This meant that staff may not be aware of the person's aims and therefore would not support them in this.

One healthcare professional said they had been told by a senior member of staff that "CQC had told Little Acorns to stop people's daily routines that have been established, resulting in my witnessing four people sitting around unsupported without staff on one of my visits and not engaging meaningfully in any activities." CQC had not given this feedback following the last inspection. Feedback included asking the provider to consider ensuring people were given choice in the types of activities they wished to participate in.

A healthcare professional described how they had recommended that a person should undertake a particular outdoor activity which they should be able to do as an individual supported by a member of staff who they liked. However the healthcare professional said they were told that the activities had stopped as the person did not enjoy them. On further discussion, the healthcare professional said they had then found out that the person was being taken by staff they did not get on with or like. They also found out that the person attended these activities as part of a group. The health professional also added that the person had never been provided with any regular opportunity to pursue their love of trains with a weekly individual train journey as had been recommended and agreed with the person. The person's daily records showed this type of trip had not occurred.

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

A person receiving personal care in their own home said they thought the care they received was good. They described how they were supported to do things that interested them. We observed staff taking time to discuss options with the person and helping them to plan their day to accommodate their wishes

Some people we spoke with said they liked living at Little Acorns. One person also said that the service had improved in some ways since the last inspection and they now had less restrictions placed on them in terms of what they did in the home.

Our inspection in March 2015 found a breach of Regulation 19 of the 2010 regulations (Complaints) which is now

Inadequate

Is the service responsive?

covered by Regulation 16 of the 2014 regulations (Receiving and acting upon complaints). We found people's views were not actively sought about the service and there were no systems in place to encourage people to raise concerns or complaints. People were not actively supported to raise complaints.

We found there had been some improvement that complaints were now dealt with effectively. For example we saw a senior member of staff had acknowledged a concern made by a family and had responded to this appropriately. We were, however, unable to view the complaints log as we were told this had been sent to be reviewed by an external body. One relative said they were frustrated with the registered manager/provider as they had contacted them to make a complaint and seek answers and their requests had not been responded to.

Inadequate

Is the service well-led?

Our findings

Our inspection in March 2015 found a breach of Regulation 20 of the 2010 regulations (Records) which is now covered by Regulation 17 of the 2014 regulations (Good governance). We found people's records were not kept securely to maintain confidentiality. Records were not accurate and some were poorly maintained.

During this inspection, we found the care records in Little Acorns showed very little evidence of any changes being made. Risk assessments and care plans had not been updated and there were gaps in completing daily records. Financial records for people were not kept up to date. However we did find some improvements in the records relating to people receiving personal care in their own homes, which had been updated and provided an accurate record of the care provided. This was not the case for people's records at the care home, Little Acorns.

During the previous inspection, we had received information from the Nominated Individual, who was also the registered manager, about their future plans for the management of the service. The registered manager said they had stepped down and were no longer in day to day charge of the service. We were also told that a senior member of staff was going to apply to become the registered manager.

Since the last inspection, there had been several changes to the senior management team. We had been told on different occasions of two different members of staff who would apply to become the registered manager. However, these changes to management have not been sustained. We received information of concern about the registered manager's approach to ensuring that the service was well-led through these intended transitions.

We reviewed a letter from the registered manager to a member of staff which stated that the registered manager had officially resigned and no longer had anything to do with the service. However the administrator told us the registered manager was in most days. The management team indicated that the registered manager was still in charge of making day to day decisions. However, the registered manager did not meet with us during the current inspection to discuss our findings, despite our request to provide feedback to her.

Following the publication of the previous inspection report, we requested that an action plan should be submitted by the provider to show how they planned to address the concerns that had been identified. The action plan should have been submitted to us by 22 July 2015. We had not received this by the end of July 2015. During our inspection in July, we advised the senior staff that we were still waiting for the action plan, which they said they were unaware of. At a safeguarding meeting attended by the registered manager and an external consultant they had employed, we were presented with a copy of an action plan. We raised some concerns about the action plan as it did not provide information about dates when actions would be completed. Following this meeting in August, we received a revised action plan which established dates for completion of actions.

We were made aware of a concern about the management of one person's money and how this was being managed. When we asked if other people's money and records had been checked and audited we were told this had not yet happened despite concerns about one person's finances that had been identified. There had been no audits on people's finances externally to ensure their protection. Quality assurance audits were not routinely taking place as senior staff said they were too were busy trying to cover shifts and complete care plans and risk assessments. This meant that people were at continued risk of being financially abused.

We asked if senior staff had shared the last inspection report, summary and easy read report with people using the service, their families and with staff. Senior staff said they were aware the report had been published but had not yet seen the summary or easy read documents as they had been sent to the registered manager who had not shared them. Senior staff said they were aware that some relatives had seen the CQC report. They also said that an external consultant brought in by the provider had talked with relatives within a meeting held in July, but there were no minutes of this meeting available.

The management team the provider had put in were working hard to try and make some positive changes, but the lack of clarity or openness by the provider in not sharing information, meant that their efforts were being negated. For example they had been told that it had been

Is the service well-led?

agreed that waking nights could operate with one member of staff. This was not agreed by the commissioning team and the home was funded for two waking night staff and one sleep in staff to keep people safe.

One person was having a respite care service in the home of other people who received personal care from this service . It was unclear how this had been agreed, given that people had their own tenancy agreements and only received their personal care from the service. A respite person would not have the same tenancy agreement as a person living full time at a leased property.

We heard that although there had been family and relative meetings there had been no recent resident meetings, in which people could have heard about why staff had been leaving, the last inspection report and what choices they would like to make for future activities. There was no evidence these areas had been discussed with people in any other way, such as with their key worker as part of a review of their plan. This did not demonstrate an open culture.

There was little evidence that incidents had been reviewed and lessons learnt. One manager said they had started a book with incidents so they could track any trends, but this was only just being developed. There had been a number of serious incidents involving people hurting other people in the service. This had not been reported to CQC as they were notifiable incidents, nor to the local safeguarding team. The information from incidents had not been fully analysed.

Statutory notifications the service are required to submit to CQC had not been submitted. These included notifying us about people who had an approved DoLS in place and serious incidents of possible misconduct and abuse by staff. For example, some Deprivation of Liberty Safeguards (DoLS) authorisations for some people had been granted in May 2015, but these had not been notified to CQC.

When senior staff saw they were unable to provide staffing for one person in the local community, they asked another agency to take over the contract, without first consulting with the person whose care they were handing over. One relative said they felt “let down” by the provider as they had not had a response from their contact with them, despite repeated requests. Another said they were disappointed in the provider as they had not delivered the care and support they had promised. This showed a lack of consultation or openness with families and people using the service.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People were not protected against the risk of unsuitable or unfit staff working in the service as pre-employment checks were not robust.

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient staff to support the needs of the people. Staff had not always received support and training to enable them to carry out their duties effectively

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Risk and needs assessments had not always been carried out and most risk assessments were generic. Care plans were not always person centred and did not always meet individual needs.

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not always receive safe care and treatment. Medicines were not always administered and managed safely.

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

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 People were not always safeguarded from the risk of abuse.

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent was not always sought. Where a person did not have capacity to make a decision, the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards had not been followed.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of management and leadership. There were not robust systems in place to monitor and improve the quality of care.

The enforcement action we took:
In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.