Potensial Limited

Avondale Lodge

Inspection report

6-7 Nelson Terrance
Redcar
Cleveland
TS10 1RX

Tel: 01642494509
Website: www.potensial.co.uk

Date of inspection visit:
08 August 2017
15 August 2017

Date of publication:
20 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Two adult social care inspectors carried out an unannounced inspection at 02:00 on 8 August 2017 and at 07:00 on 15 August 2017. The inspection was in response to two alleged incidents which took place at the service. The Commission made a decision under its own 'Handling Serious Incident Guidance,' that it was necessary for it to attend the service and make inquiry into the incidents, as well as to assess the risk to people using the service.

The last comprehensive inspection was carried out 21 June 2016 and the service had been rated 'Good' overall.

Avondale Lodge provides care and accommodation for up to 12 people who live with a learning disability. At the time of our inspection there were 12 people using the service. The service consists of two Victorian houses which have been adapted to become one service and is situated in a residential area of Redcar, close to the sea front and local amenities. People have their own bedrooms and access to several communal areas. There are gardens to the front of the service and two small courtyards to the rear.

The registered manager has been registered with the Care Quality commission since 1 October 2010. 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 received care which placed them at on-going risk of harm. Incidents and safeguarding concerns were not always recorded or reported. Care plans and risk assessments were not reviewed when incidents took place and measures were not put in place to reduce the risk of potential harm to people and staff.

Information was not routinely shared with the Commission, Police and local authority safeguarding team when investigations of incidents and safeguarding concerns took place. The provider did not take appropriate action to investigate incidents themselves and did not always carry out the actions which they were directed to do so by the safeguarding authority.

Not all staff spoken with were aware of personal emergency evacuation plans for people. This is information to assist emergency workers to safely evacuate people. On the first day of our inspection we found that of the five available evacuation routes three were locked. We contacted the fire authority who visited and made recommendations around maintaining accessible fire exists. Health and safety certificates were up to date.

There were not enough staff on duty at night to evacuate people during an emergency, such as a fire. There were insufficient staff on duty during the day to ensure all of the contracted one-to-one hours were provided or people who did not have additional support had staff available to assist them. Appropriate staff numbers

had not been planned in advance, staff rotas were inaccurate and staff were working excessive hours.

People had access to their prescribed medicines and these were available in sufficient quantities. Medicines records were not person-centred. This meant staff did not have the information they needed to determine whether people with communication difficulties, and did not have capacity to tell staff whether they, needed their 'as and when required' medicines.

Staff training was not up to date and competencies had not been reviewed when incidents took place at the service. Staff did receive supervision; however these did not address incidents, safeguarding concerns or individual areas for improvement.

Care plans and risk assessments were not updated when people's capacity changed or was reviewed. People deemed not to have capacity were able to access the community on their own without oversight from staff to ensure they remained safe to do so. Even though at times people raised concerns about these individual's behaviour.

Appropriate action was not taken to actively monitor people at risk of malnutrition. This included people who were losing weight or were at risk of choking.

People did have contact with health and social care professionals. Care records were not updated following these visits or in light of new recommendations.

People avoided specific areas of the service because other people displayed behaviours which challenge. As a result of these behaviours, we found that furniture and decorative items were removed from communal areas. Some areas of the service required updating; there were holes in walls, carpets were stained and bathroom flooring had started to lift.

Staff told us they had enjoyed working at the service, but told us they currently struggled to provide safe care and support to people.

People were not involved in planning and reviewing their care. There was no evidence in care records to show that people had been asked about their care and we did not observe people being asked during the inspection.

People's privacy and dignity was not protected because staff failed to follow positive behaviour support procedures which meant people were not protected from harm and abuse. People were aware of confidential information about other people and about the day to day running of the service. People's dignity was not maintained during mealtimes.

People did not receive person-centred care. Care records did not reflect current individual needs. The difficulties staff faced meant they were providing task led care to people and there was no evidence of any appropriate stimulation for people.

No complaints had been made since the last inspection. A complaints policy and procedure was in place.

Staff told us they stopped raising concerns because the manager was not supportive and did not listen to them. During the inspection, the manager was in the communal areas and failed to notice that staff were visibly upset and struggling to manage people.

Quality assurance procedures had not identified the level of concerns outlined in this report. At times the care and support provided to people was unsafe because it was carried out in a way that increased the risk of harm to people. The service was not meeting the provider's policies and procedures and action had not been taken to address this. As a whole, the service was failing to respond quickly to the risks people and staff faced.

The provider failed to ensure that all directors, the nominated individual and registered manager had taken reasonable steps to ensure people were receiving safe care by way of quality assurance and monitoring of the service. This led to the service being found in Extreme Breach of the Health and Social Care Act 2008.

We asked the provider to carry out a competency review of the manager in light of the findings during this inspection. The findings of this review were not carried out within the timescales outlined by the provider and did not address any of the concerns which we shared with them.

The directors and the nominated individual for Potensial Ltd's had not taken reasonable steps to reduce the risk of harm to people. No robust procedures were in place to ensure staff remained competent to provide safe care and treatment to people and take appropriate action where staff are no longer fit to carry out the duties expected of them.

Following the first day of inspection we wrote to the provider to express our concerns about the service and asked them to supply us with an action plan which outlined what action they would be taking to make improvements. We asked them to review this action plan again because we felt the areas for improvement were not robust and timescales needed to be tighter.

We wrote to the provider again following the second day of inspection to outline our continued concerns because we felt the risks to the service had increased. Responsive action had not been taken in all areas and we remained concerned about the registered manager because they did not appear to be fully aware of the risks in place, the action needed to minimise these risks or be aware of the robust leadership needed to make timely improvements, ensure people were safe and that staff are supported.

Throughout inspection we have shared our concerns with the relevant local authorities and clinical commissioning group (CCG) and have continued to do so afterwards.

We found 11 breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, safe care and treatment, safeguarding, quality assurance, staffing and fit and proper persons employed. We also identified a further breach in the Care Quality Commission (Registration Regulations) 2009 by way of failure to make statutory notifications.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Staff did not always follow the procedures in place to keep people safe. Safeguarding concerns and incidents were not always reported. People and staff were at risk of on-going harm.

Care plans and risk assessments did not accurately provide information about the risks to and from people. They were not reviewed when incidents took place and appropriate measures to reduce risk were not put in place.

There were not enough staff on duty at all times to keep people safe. Sufficient staff had not been planned in advance which meant staff rotas were not accurate. People did not receive their funded one-to-one care.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not up to date. Competency checks were not carried out when incidents took place at the service to determine whether staff remained competent to carry out their roles.

People at risk of malnutrition or choking had not been appropriately monitored and no measures put in place to reduce those risks.

All areas of the service were not used by people because people isolated themselves away from other who displayed behaviours which challenge. Furniture and decorative items had been removed from communal areas. Some areas of the service required updating.

Is the service caring?

Inadequate

The service was not caring

Not all staff were aware of people's individual support needs and strategies in place to manage behaviours which challenge.

People's privacy and dignity was not respected or maintained because people experienced harm and abuse. Staff did not follow positive behaviour support strategies to keep people safe.

People were not involved in planning and reviewing their care. People did not receive meaningful interaction and activities from staff. Care was task led.

Is the service responsive?

Inadequate

The service was not responsive.

Care records did not contain accurate and up to date information about people's individual needs, risks and behaviours. These records did not match the information which had been recorded in a communication book. Staff did not understand the evaluation process for people's care.

There was a lack of meaningful activity and interaction with people when they were at the service. There was no evidence of planned activities for people which reflected their individual needs, wishes and preferences.

A complaints policy was in place. No complaints had been raised since the last inspection.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not have adequate oversight of the service. People continued to be at risk of harm. Robust action was not taken to make significant improvements.

Staff were not supported to deliver safe care and support to people. They did not feel able to raise concerns because they did not feel listened to. Staff told us they stopped raising concerns about people and when they were assaulted.

The provider was not actively managing and assessing the risks at the service to ensure safe care was provided. Quality assurance procedures had not highlighted the concerns identified during this inspection.

Avondale Lodge

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 registered 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.

Before the inspection we reviewed all of the information we held about the service. The information included notifications that we had received from the service. Notifications are changes, events or incidents the provider is legally required to let us know about. We contacted Redcar and Cleveland local authority and safeguarding teams and reviewed minutes from Redcar and Cleveland local authority provider meetings which we attended.

The provider was not asked to complete a Provider Information Return (PIR) because a decision was made to carry out this inspection quickly. This meant there was not the time to request this information. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The last PIR was requested 11 February 2016.

Two adult social care inspectors attended the service for an unannounced inspection at 02:00 on 8 August 2017 and left at 08:00. They returned for a second day unannounced inspection at 07:00 on 15 August 2017 and left at around 16:30. This meant we could meet with people using the service and the registered manager. During the inspection we spoke with the regional manager, registered manager, five care workers, two care workers from a day service within the providers portfolio of services and two agency care workers. We also spoke with three people using the service.

During the inspection we reviewed eight people's care records. We reviewed the supervision and appraisal records of 13 staff, the medicines competency records for nine staff and the training summary records for all staff. We also reviewed records relating to the day to day running of the service.

We looked around the service and went into some people's bedrooms (with their permission) and visited the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us."

Inadequate

Is the service safe?

Our findings

People who displayed behaviours that challenge, with the potential to cause harm to other people, had not been identified and the risks recorded into their support plans and risk assessments. This meant staff were not fully aware of the risks people could pose or how to mitigate those risks. When incidents took place, staff did not respond appropriately to reduce the risk of reoccurrence or followed the provider's policies and procedures. In notifications to the Commission about incidents, staff who completed them regularly stated people were in the 'wrong place at the wrong time,' when they were assaulted by other people. This showed that staff had failed to understand the risks to people and failed to take appropriate preventative action to reduce the risk of harm to people.

Assaults on people and staff were common practice at this service. During inspection, staff openly discussed their concerns and fears about coming into work, the difficulties they faced at work trying to deliver safe care and support to people and the effects of this on their own health and well-being.

A safeguarding alert was raised by a health professional because they observed a staff member using unauthorised physical intervention techniques. After inspection, we were informed that the alert was substantiated which meant abuse had taken place. No action had been taken by the provider or manager in light of this, such as refresher training for the staff member or revisiting the person's positive behavioural support plan. An internal investigation of the incident had not been carried out. During discussions with the safeguarding authority, the manager told them this staff member was not providing one-to-one support to the person named in the safeguarding alert. On the same day we observed this staff member providing one-to-one support to the person and was allocated on the staff rota to provide this support for six hours. This meant this person had been exposed to the risk of further harm.

Where safeguarding investigations had taken place by the safeguarding authority and Police, the provider had not shared with them relevant information about known risks and behaviours which challenge. Where incidents and safeguarding investigations had taken place, no discussions had taken place with staff about risk management, record keeping, making safeguarding alerts or dealing with assaults by people towards staff and other people using the service.

Checks of agency staff were not carried out to ensure they were competent to work at the service. This meant the manager could not confirm if agency staff had received training in the application of positive support plans and the associated use of physical interventions to manage behaviours which challenge. This meant people and staff were exposed to the risk of harm.

After the first day of inspection, in response to our concerns, the provider told us their safeguarding and escalation policies and procedures to all of the staff team at the service would be re-launched by 11 August 2017. There was no evidence available during inspection to support this on the second day of inspection. Policies had not been reviewed to ensure they remained accurate; staff were not aware of them and were still not raising and reporting incidents and safeguarding concerns. No supervisions or competency checks of staff had been carried out to check staff competency in this area.

This was a breach of regulation 13 (Safeguarding people from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that action was not always being taken to record and report all assaults or incidents to the safeguarding authority or CQC. There had also been no consideration given to whether the police should be notified of these matters or the Health and Safety Executive, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDORS) under the Health and Safety at Work Act 1974. These regulations means employers and responsible persons in the workplace are responsible for reporting specific incidents and accidents in the workplace.

Staff carried out actions which were known to increase behaviours which challenge, this included unfamiliar staff supporting one person which was a known trigger for their behaviours which challenge. From the staff rotas reviewed, we could see this was a regular occurrence. Safeguarding alerts had not been made at the time these known risks had been displayed, nor had notifications been made to the Commission. Important and relevant information was not disclosed to the Commission, safeguarding authority and police when incidents had taken place.

Staff had failed to recognise when people's behaviours were changing, such as when people known to assault other people, targeted someone new. Staff also failed to ensure new and agency staff were aware of people who could display behaviours which challenge. Inspectors observed one person physically assault an agency staff member who was clearly unaware of the potential for this behaviour to be displayed. Inspectors saw that staff failed to carry out appropriate action, check the agency staff member was okay, ensure infection prevention and control procedures were followed or report the incident to the manager and complete an incident record. We raised a safeguarding alert in relation to this and after inspection we were told by the local authority that this alert had been substantiated.

One person's records indicated that a measure had been put in place to reduce risk, however this was not the case during this inspection. Staff had failed to update these records after taking advice from the local authority safeguarding team. Measures put in place to manage risks following incidents were not reviewed adequately. Care records showed risks continued after incidents occurred, however no action was taken to continually manage these risks. We noted that some measures, such as increased checks of people, put in place following incidents were impossible for staff to follow because of the layout of the service and the number of staff on duty to facilitate this.

One person had an additional mattress and duvet in place on the floor of their bed as a replacement for a crash mat. Staff had put a duvet in place because they felt this led to a reduction in it being a fall or trip hazard. No risk assessment had been completed around using this non-standard equipment or no advice sought to confirm that the mattress would not pose a risk to the person. The manager had not taken action to order a new crash mat.

The manager told us people were regularly checked during the night; however there were no records in place to support this. From speaking with staff we found they did not carry out the checks needed. Part of this was to minimise the risk of behaviours which challenge by one person. One staff member told us, "The more the [night] checks are done, the more we are disrupting people. The floors creek and all the doors are fire doors. This disrupts [person using the service]." Minutes of a staff meeting dated 3 August 2017 stated that three people using the service had checks in place which staff needed to carry out. However these were not available on the first day of inspection and staff were not aware of them.

During our night visit to the service, we observed staff carrying out checks without shoes and in dim lighting.

They told us, "Lights have to be down and we have to be quiet." This was in relation to an incident earlier in the night. We found this practice was not safe for staff.

From speaking to staff and reviewing care records, we could see that one person required needed two to one support at times and 11 people needed at least one to one support. However they were only two staff on duty at night. We found the fire procedures required one staff member (the person in charge) to co-ordinate the evacuation and the other staff to actively assist people to leave. We found that having two staff on duty was insufficient to both deal with emergencies and support people. We wrote to the provider and they confirmed that an extra member of staff would be on duty overnight until they completed their investigation.

On the second day of inspection, three staff were allocated to night duty. The waking night checklist stated one staff member must be positioned on the landing of house seven at all times. If that staff member needed support they had to ring the landline for the service. This meant there could be a delay in responding to the staff member who required assistance and also increased the chances of disruption to people sleeping during the night.

Start did not take action to check the location of each person when they started their shift. This meant staff could not be sure that were safe and their needs met. A safeguarding alert had been made on 31 July 2017 because one person had been left in their chair in their bedroom all night without any support to get ready for bed. This meant this person had slept in the chair in their day clothes all night. This person had gone unnoticed because staff did not carry out any checks, despite measures in place to check this person every two hours. After inspection, the local authority informed us that this safeguarding alert had been substantiated.

On the second day of inspection, health and safety checks were being carried out and records were in place to support these checks. However the times of these checks had been pre-populated. This meant that all 12 people were required to be checked at the exact same time. We also noted some people retired to bed before 22:00 when these checks started. From the available records, these people were not checked prior to 22:00. Despite feedback from Redcar and Cleveland safeguarding team about these records prior to the second day of inspection, changes had not been made.

Following a previous incident, staff were required to respond to one person if their bedroom door alarm was activated. If any concerns were noted then a check of everyone using the service needed to be carried out. We noted it would be very difficult for staff to carry out all of these checks in the time needed.

Not all staff we spoke with were aware of the personal emergency evacuation procedures (PEEPs) in place for people. These are records with information for emergency workers to safely evacuate people. They contain important information such as people's mobility, medicines and health conditions. This meant that staff did not have the knowledge needed to evacuate people during an emergency.

The provider's fire procedures records stated that the person in charge was to supervise those who left the building, which meant that when only two staff were on duty, one staff member would need to ensure all of the service users, inclusive of those with mobility needs. On the second day of inspection, we found none of these staff members had been allocated to be the 'person in charge.' Staff were concerned about this as this role is needed for emergency events and incidents taking place during the night.

We reviewed the fire precautions and procedures. One exit was locked as staff were storing equipment in the foyer to prevent a person being able to use the items as weapons. Two exits were located in the kitchen and

laundry with both going to a small courtyard. The gate from this courtyard was padlocked. We found the fourth door was the main entrance to the service and when visited the internal door from the foyer stuck so we could not get in and the staff member who had opened the main door had to knock on the window to alert the other staff member that we all were locked out. The fifth door led to a larger courtyard, which was open but had garage doors that were padlocked. We found these measures were unsafe and asked the fire authority to visit. The fire authority made recommendations about how to ensure the fire precautions were appropriate.

People were observed not always receiving their allocated one-to-one care. This was because staff had failed to inform the manager that there was a shortage of staff. We observed staff regularly leaving the people they were providing one-to-one support to. We raised two safeguarding alerts because people were not receiving their one-to-one care. These were substantiated.

Protocols for people who required medicines on an 'as and when required' basis were not individual to people. Three people had an 'as and when required' protocol for Paracetamol; the information in each of these protocols was the same, only the name had changed. In each of the three protocols, it stated that each person would touch their head to display they were experiencing muscular pain. Some protocols reviewed did not include information to show the person would need their medicines or the quantity. Medicines audits had not highlighted these omissions.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff on duty during the day and at night to provide safe care and support to people. This meant care was being delivered in ways that placed people at risk of exposure to significant risks to their health, safety and welfare.

At inspection on 8 August 2017 two staff were working night duty. Staff were responsible for providing care and support to 12 people, carrying out observations, responding to door alarms as well as completing a range of other tasks including laundry and cleaning. We could see people regularly got up during the night. From our observations we could see there was not enough staff on duty to carry out the duties expected of them safely.

Following the first day of inspection, we contacted the provider and asked them to increase staffing levels at night which they did. From our discussions with staff and review of staff rotas during inspection on 15 August 2017, we found agency staff had been allocated to each night duty. Agency staff had been positioned on the landing at one side of the service to observe and support people. This meant the two remaining staff were left to carry out all of the remaining duties. We concluded from speaking to staff and from our observations that because the third member of staff was positioned on the landing they had not proven to be a resourceful and supportive measure. From our review of the staff rotas' we could see there were other nights where one member of staff was working with two agency staff. This was not safe because the provider did not allow agency staff to provide support to people displaying behaviours which challenge.

At inspection on 15 August 2017, we found there were insufficient staff on duty during the day. We told the manager that one person was not receiving their one-to-one support. The manager told us the name of a staff member allocated to this one-to-one support, however this staff member was supporting another person in the community. When we told them this, the manager told us they were providing the 1:1 support. However we had not observed this at any point during our inspection. The staff rota showed that this one-to-one support was being provided by a staff member currently on leave. Rotas had not been updated to

show changes at the service.

The manager responded to our concerns about the lack of staff on duty and two staff from a day centre, within the provider's portfolio attended the service. Inspectors found them in communal areas with people, staff did not know who they were or had not been told they would be attending to support people. We spoke to these staff members and concluded that they had not been given sufficient information about the people they were supporting. They couldn't give information about individual care needs or had not been given time to review people's care records.

The manager told us there was one vacancy that they were in the process of recruiting a person to fill. They also told us that the current staffing numbers of nine support workers (four of whom worked night shift), three team leaders, a deputy manager and manager would be sufficient to cover the one-to-one hours as well as provide support for the four people without one-to-one support. On 15 August 2017 we reviewed all of peoples' admission profiles on the electronic care records system (CARESYS). We noted that eight people received additional hours of one-to-one support; in total this was 320 hours 30 minutes of additional one-to-one support were to be provided. From our calculations, we determined that the 14 members of core staff in place at the service was insufficient to provide cover.

No pen profiles were available for the agency staff in place at the service. This meant that the service did not have a photograph of the care worker they were expecting and information relating to their qualifications and experience. No procedures were in place to ensure all agency staff were aware of the layout of the building, relevant policies and procedures and procedures relating to the care and support of people

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

Quality assurance procedures had failed to identify that the service was not safe and that people and staff were continually at risk of harm. No review of staffing levels had taken place when incidents had occurred, which meant that reasonable and practical action had not been taken to reduce risks to people.

The provider had not considered the impact of their policy to not allow agency staff to provide care and support to people displaying behaviours which challenge or males to provider personal care. Neither had any reviews of night duty taken place to identify that the use of agency staff was detrimental to permanent staff on duty or to determine whether more staff at night were needed to provide safe care.

Excessive working hours had not been flagged up by the provider to determine whether staff were overtired and therefore more likely to make mistakes or misjudge situations. The staff rotas showed staff were working in excess of 60 hours per week and sometimes up to 80 per week, with some staff completing 14 hour shifts. Night staff were planning to work six consecutive night shifts from 22:00 until 08:00 because the rota had placed one member of permanent staff with two agency staff. Staff were taking this action to safeguard themselves.

The manager failed to take action with one staff member when a safeguarding alert was raised for using inappropriate physical restraint. We were concerned that the manager only took action when directed to do so by the safeguarding authority.

Staff rotas had not been updated to show changes at the service. This meant the information contained within them was not always accurate.

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

Systems were in place for the management of medicines at the service. People had access to all of their prescribed medicines when they needed them and they were ordered in timely manner. Regular checks of these medicines had been carried out and medicine administration records (MARs) were up to date. Staff demonstrated good knowledge about people's medicines. Although the information contained in people's 'as and when required' medicines protocols was limited, staff were aware when people required these medicines. Staff told inspectors about the signs and symptoms people could display when they experienced deterioration in their health and well-being, when medicines were required and the action they would take if no response was noted from these medicines.

Health and safety checks of the building had been carried out. Certificates were in place to show that up to date health and safety checks of the building were up to date.

Inadequate

Is the service effective?

Our findings

The measures in place for supporting staff, such as supervision, appraisals and training did not ensure they remained competent to deliver care and support to people. From our observations, we could see that staff were not following their training, policies and procedures.

Prior to June 2017, staff had received regular supervision, however there were gaps in the frequency after this time. Supervisions had not addressed the number of incidents and specific incidents which had been occurring at the service. No supervision sessions had been carried out with staff after we raised concerns about the service during the inspection. When we spoke with staff on the second day of the inspection, they were not aware of the concerns which we had raised about the safety of people at the service.

Appraisals were not fit for purpose. Where we asked for an appraisal to be carried out in light of our serious concerns, we found the appraisal did not address the concerns raised. The provider had reviewed the staff members last appraisal rather than carry out a new appraisal.

Staff training was not up to date; this included health and safety, food hygiene, mental health, autism and learning disabilities. There was evidence that safeguarding, positive behaviour support and fire safety training had been booked. Competency checks or reviews of training, such as positive behaviour support had not been carried out despite evidence to show that staff had failed to follow the correct procedures.

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

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 found the service was not always working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The records showed that some best interest decision making had taken place, however there was a lack of information contained in support plans and risk assessments in relation to these decisions. Other records made reference to best interest decisions; however no documentation had been completed. This included a best interest decision to forgo a medical examination.

We reviewed the records for one person who was subject to a DoLS authorisation and found they routinely went into the local community and travelled further afield on their own by bus. Staff had not reviewed the

person's safety and the safety of other people whilst they were out in the community. We saw that members of the general public had raised concerns about an individual's presentation when in the community but no action had been taken to review this and the current practice. Thus the provider failed to comply with the terms of the DOLs authorisation that was in place to protect them by way of their vulnerability under the Mental Capacity Act 2005 or mitigate health and safety risks to themselves.

Staff had not considered whether risks people posed to others might be of a threshold that would lead to consideration of the use of the Mental Health Act 1983 (amended 2007) and others. Staff on occasions recorded the time the person left the service and returned, however these were not consistently completed and there was no information in the person's care records to show why this monitoring was in place. We saw that staff would shadow an individual to their college and it was noted that the person was likely to distract bus drivers so staff were to intervene. However, the person came home alone from college but there was no information to show why the risk of them distracting the bus driver was lessoned on an afternoon. No risk assessments were in place and there was no information to indicate what action would be needed if concerns were raised about the person's behaviours.

A DoLS support plan for one person showed their DoLS remained valid. The support plan stated, "A form 10 review was submitted on 5 April 2017 due to a change in restrictions." This form is to request a review of the person's DoLS because there had been a change in the person's circumstances. There was no information about the reason for this and the support plan not updated to show what these changes to the restrictions were. Staff were not aware of what these changes were when we spoke with them.

This was a breach of regulation 13 (Safeguarding people from harm or abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans and risk assessments had not always been updated when people had received visits from health professionals. We identified that one person was at risk of choking. Nutritional support plans and risk assessments did not include any information about this. This meant staff were not appropriately monitoring and reviewing the risks to this person. Risk assessments for people at risk of malnutrition had not been regularly completed.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the building required updating; however the registered manager's competency assessment stated they had gone over budget on repairs. Carpets throughout the communal areas of the service were stained and bathroom flooring had started to lift. Paintwork was in need of updating, doors ways were scuffed and the wood damaged and there were holes in walls. The environment was dated. No action plan had been put in place to show when repairs and improvements would be carried out.

Throughout the inspection, we observed that the service was not properly used or maintained. On the second day of inspection, we found that people did not have access to the music room because a meeting with staff and health professionals was taking place. No quiet alternative space was made available for people. We saw the majority of people and staff located themselves in the same lounge which meant it was noisy and over crowded. There were not enough seats for everyone and this room was also an access route to other rooms in the service. When rooms were overcrowded, we observed that the behaviours of one person increased during this time. Some people told us they avoided using areas of the service where people were displaying behaviours which challenge. We observed this to be the case.

People and staff told us that there was a lack of items on display and furniture had been removed because of the behaviours of one person. Cards, posters and pictures on display had been pulled down and not replaced. There were holes in the wall in the dining room which had not been repaired. A dining room table designed to seat eight people had three chairs, this meant people could not sit together at mealtimes. The outside areas were not designed in a way that was accessible to people. For example, there were no tables and chairs, items of interest or activities in courtyards. During inspection we did not observe people access the front gardens or courtyard areas.

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

Inadequate

Is the service caring?

Our findings

People's privacy and dignity was not maintained or respected. Staff did not follow behaviour intervention strategies which meant people suffered physical and verbal abuse from other people using the service. People's personal possessions were not protected because people went into other people's rooms and took items. Although this was a known practice, no measures had been introduced to look at this.

When we spoke with people, we identified they were aware of confidential information relating to the day to day running of the service and about other people using the service. This included information about staff shortages, excessive working hours and the well-being of staff. We identified that some people were isolating themselves to avoid people who were displaying behaviours which challenge. People told us they did not like to see these behaviours.

On the second day of inspection, we observed staff preparing a lunch of toasted crumpets with melted cheese. These were all placed onto a large serving plate. Staff were observed handing these to people and putting them into their hands or breaking pieces of the crumpet and placing these pieces directly into people's mouths. Staff were not wearing gloves, people did not have access to plates or napkins and people were not given the opportunity to sit at the table to eat their lunch.

This was a breach of regulation 10 (Respecting and maintaining dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence to show people were involved in planning and reviewing their own care. When we spoke with people they confirmed this to be the case. There was also little evidence of varied choices throughout the day for people. For example, we saw that one person was given the choice of the park or the beach. Staff told us this was always the case. There was no evidence to show the person was ever given other choices in line with their hobbies and interests.

People told us they isolated themselves away from people who displayed behaviours which challenge. We could see that they were not always able to go out into the community because staff were busy. This meant they spent a lot of time in their bedrooms. When people remained at the service and were not in receipt of one-to-one care, they were left without any staff involvement.

Staff told us they enjoyed working at the service but discussed the difficulties they were currently facing and wanted change. From our observations it was clear that some staff worked hard to make sure people's basic needs were met and talked about people in a caring and compassionate way. One staff member told us, "All of the service users are lovely." There was evidence that some staff worked together as a team, however care appeared to be task led. From our observations staff were juggling the different duties they needed to complete. This at times was chaotic as staff were working in conditions where there was a lack of leadership and insufficient staff to ensure people received the care they needed.

Not all staff were aware of peoples individual needs and they were not aware of people's individual support

needs and strategies in place to manage behaviours which challenge. This included the guidance in positive behaviour support plans. This information was not shared with agency staff.

During the inspection many staff were tearful and expressed their disappointment that they were not able to deliver the care and support they needed. They expressed their concerns about the situation they were facing on a daily basis; this included the level of behaviours which challenge, assaults on people and staff and staffing levels. Staff told us they did not look forward to coming to work because of what they anticipated they might face.

Staff were not following the policies and procedures expected of them. When people displayed behaviours which challenge, it was clear that staff were displaying difficulty managing these situations. Whilst staff could, at times swap with one another, this was not always the case and the rotas were not designed in ways that allowed staff to have breaks. We found that they would be allocated to complete extended periods of in excess of four hours without a break in the one-to-one support they were to provide.

When staff took people out into the community, this left the remaining staff under increased pressure. We observed staff trying to deliver one-to-one support whilst trying to observe another person, answer the door and get drinks for people. When in the service staff on one-to-one support were only able to rotate with each other so never stopped providing this level of support.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Care records were not person-centred and did not reflect people's actual needs, wishes and preferences. Pen profiles for each person did not contain information about why people were using the service, the support needed or any details about their capacity. This meant that new and agency staff did not have the information they needed at a glance.

Although there was a lot of information in care plans, the information contained within each care plan was brief and did not provide sufficient detail to allow for person-centred care to take place. The reviews recorded within people's care records did not match their actual care needs. There was limited information about why people presented with specific behaviours, what staff needed to do and what action they needed to take to minimise the risk of reoccurrence.

Care plans were in place despite no actual care needs in those specific areas. The number of care plans in place had meant that staff had not reviewed them collectively and thus, had not picked up on current issues, such as increased behaviours or behaviours being targeted to specific people. For example, staff were not aware that one person needed increased checks following an alleged incident or another service user had a new care plan in place.

The regional manager, manager and staff did not understand the processes for evaluating people's care. The current processes in place for evaluating people's care was limited and did not lead staff to consider if care plans were working, contributing to other issues or were creating more difficulties for the person.

We observed a lack of engagement for people who remained at the service during the day. They found staff were engaged in trying to manage the day to day running of the service and thus did not have time to actively engage with people. Although staff were providing one-to-one care to people at times, there was a lack of engagement during these times too. We observed that the behaviours of one person displaying regular behaviours which challenge were impacting on other people using the service and their individual routines. We also observed staff struggling to deal with this person's behaviours, which people were observing too.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's personal information was not protected because we found care records on display in communal areas. This meant people's information was not being stored confidentially

Quality assurance procedures in place had not highlighted that support plans did not contain up-to-date information about people's individual needs. They had not recognised that staff did not always have the information they needed and agency staff had not been provided with the information they needed to support to people. Audits of support plans and risk assessments had not identified areas of concern that had been missed during reviews. No observations of practice had been carried out to determine whether

people were receiving appropriate support and whether this was in-line with their support plans and if they were accurate. Quality assurance systems had not recognised that staff lacked understanding about the care evaluation process.

There was no evidence to show that any observations of people had been carried at the service to ensure they were receiving meaningful activity or had appropriate and suitable engagement from staff. This would have shown people were not receiving appropriate engagement as a direct result of people who displayed behaviours which challenge and staff who were no longer able to because of the day to day complexities of the service which included insufficient staff, a lack of suitably trained staff and visibly exhausted staff.

The manager and provider had not been responsive in the management of behaviours which challenge. Although incidents had occurred, the manager had not taken action to update support plans. In response to our letter of serious concern to the provider following the first day of inspection, the provider told the Commission that positive behaviour support plans would be reviewed by 11 August 2017. We found these remained unchanged when we reviewed them on 15 August 2017 and observed staff were still not carrying out actions in line with positive behaviour support recommendations.

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

Inadequate

Is the service well-led?

Our findings

A registered manager had been registered with the Commission since 1 October 2010. Our findings from inspection show that the manager had little oversight of the service and has not taken timely and robust action to ensure people received safe care and support.

They were not aware of the level of concerns which we identified during this inspection, despite the concerns clearly in place before our arrival. Although we raised concerns on both days of inspection, the manager did not respond to these concerns in a timely manner. From our observations the manager was not aware of the challenges taking place during the inspection. This included insufficient staffing levels, regular occurrences of assault and staff who appeared to be struggling to manage the situation. They had not noticed that staff were visibly upset, tired and struggling to manage the behaviours that challenge for one person. They had not offered to relieve staff struggling for a short time to allow them a break or support staff whilst there were insufficient staff to meet the demands of the day.

Staff told us they did not feel supported by the registered manager. One staff member told us, "[Registered manager] can be a nice person. But they are not a people person. They don't speak unless spoken to. There is a lack of communication, they listen but don't act." Staff also told us they did not feel listened to. They told us they had reported behaviours and concerns and potential risks to the registered manager and their comments had been dismissed. Staff told us that this meant these behaviours had continued. One staff member told us, "Staff don't speak up." Another staff member told us, "Our voice is not heard when we speak out so we don't bother."

Staff were working long hours and were allocated 14 hour shifts without being asked if this was acceptable with them. No analysis had been carried out to determine the number of hours staff were working and no monitoring of the effect of this on their health and well-being and their ability to provide safe care and support to people. Although staff meetings had taken place, they had not addressed any incidents that had taken place or discussions around how staff were feeling.

Staff told us they did not look forward to coming to work. They told us they did not know what they were going to be dealing with and knew that there was a high chance they would be assaulted without any action being taken to prevent this. One staff member told us, "[Person's] behaviour has deteriorated over the last couple of years and the outbursts are really bad. [Person] can throw dining room chairs. Morale is really low and staff are wanting to leave."

The provider was not assessing, monitoring and mitigating the health, safety and welfare of people who may be at risk. Staff had not reported potential safeguarding concerns or when incidents had occurred. They did not report when staffing levels were unsafe or when they lacked the competency to provide safe care to people. People were receiving care and support which was not in-line with their needs. At times this care and support was unsafe because it was carried out in a way that it increased the risk of harm to people. The service was not meeting the provider's policies and procedures and action had not been taken to address this.

Quality assurance measures were not highlighting the concerns the Commission has. They had not highlighted them prior to our inspection, which meant action had not been taken. Audits were not identifying that review of care plans were insufficient and that staff were not considering the effectiveness of care plans and risk assessment or the impact of unintended consequences or proposed actions. No observations of practice have been carried out which would have highlighted that staff were failing to provide basic aspects of care in an appropriate manner. Communication at all levels remained poor. As a whole, the service was failing to respond quickly to the risks people and staff faced. This meant that risks to people and staff member's safety and welfare were are on-going.

Following the first day of inspection we wrote to the provider to express our concerns about the service and asked them to supply us with an action plan which outlined what action they would be taking to make improvements. We asked them to review this action plan again because we felt the areas for improvement were not robust and timescales needed to be tighter.

In this reviewed action plan, the provider told the Commission that a quality audit would be carried out by 11 August 2017. This latest quality audit was not available to us when we carried out the second day of inspection. Despite our requests for this action plan, the manager seemed unaware of it and was not able to communicate any of the findings from it. They could not tell us what actions had been identified and if they had been addressed nor could give details of timeframes needed to make improvements.

Since the inspection we have requested this audit and have been provided with a care plan audit for three people. We remain concerned as we have been assured that a robust review of the whole service would be carried out. This would have also enabled the provider to develop their own action plan about the improvements they needed to make to ensure people received safe care.

We wrote to the provider again following the second day of inspection to outline our continued concerns because the evidence suggested the risks to the service and people safety had increased. Responsive action had not been taken in all areas and we remained concerned about the capability of the manager to drive forward the improvements needed because they did not appear to fully aware of the risks in place, the action needed to minimise these risks or of the robust leadership needed to make timely improvements, ensure people are safe and that staff are supported.

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

The provider had failed to ensure the directors responsible for carrying out the regulated activity had taken reasonable steps to ensure people were receiving safe care by way of quality assurance and monitoring of the service. This lack of appropriate oversight exposed people to a continuous risk of on-going harm as there had been a failure to provide safe care and treatment under Regulation 12 of the Health and Social Care Act 2008 and failure to evaluate and improve practice.

There was a breach of Regulation 5 (Fit and proper persons: directors) of The Health and Social Care Act 2008, Regulated Activities Regulations 2014

The provider had failed to ensure the manager is demonstrating compliance with the fitness requirements for Registered Managers. A robust competency assessment had not been completed despite our request and no competency reviews had been carried out when significant incidents took place at the service.

The manager and senior staff failed to disclose to the relevant authorities (The Police, Safeguarding and the

Commission) important and significant information about people during their investigations and under a regulatory requirement to do so.

There was a breach of Regulation 6 (Fit and proper persons: directors) and Regulation 7 (Fit and proper persons: directors) of The Health and Social Care Act 2008, Regulated Activities Regulations 2014

We asked the provider to carry out a competency review of the manager in light of the findings during this inspection. The provider said in their action plan that this would be completed by 8 August 2017. We requested this competency review record on 15 August 2017 at the inspection, however the manager and regional manager were unable to supply this. This record was supplied after the inspection and was dated 11 August 2017, however the competency review covered the assessment period dated February 2016 to July 2017. This meant the provider had not carried out the competency review by the date in their action plan. The competency review made no reference to the findings and concerns shared with them or how the provider, in light of the serious incident and multiple breaches of the Health and Social Care Act 2008, had reviewed the competency of the manager.

From the information given, the regional manager who completed this competency review had been working continuously in a different area since May 2017 and was not covering Avondale Lodge. The regional manager has not discharged their duty to ensure the competence of the registered manager in light of the findings from inspection. The provider had not taken action to review the manager's competency following an alleged incident on 9 July 2017.

There was a breach of Regulation 7 (Requirements relating to Registered Managers) of The Health and Social Care Act 2008, Regulated Activities Regulations 2014.

The directors and the nominated individual for Potensial Ltd had not taken reasonable steps to reduce the risk of harm to people. This included taking steps to examine the layout of the service and ensure people were appropriately placed. This would have increased staff observation of people and ensured the risk of harm to people was reduced.

The provider did not have robust procedures to ensure staff remained competent to provide safe care and treatment to people and to take appropriate action where staff were no longer fit to carry out the duties expected of them.

There was a breach of Regulation 19 (Fit and Proper Persons Employed) of The Health and Social Care Act 2008, Regulated Activities Regulations 2014.