Optima Care Limited

Optima Care Limited - 34 Lancaster Gardens

Inspection report

34 Lancaster Gardens,
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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

This inspection took place on 23 March 2015 and we returned to gather further information on 15 April 2015 after the Easter break. Both inspection visits were unannounced.

At our last inspection of 7 and 11 August 2014 we found breaches of regulations in relation to care and welfare of people and in supporting staff. We followed up these breaches at this inspection and found that the breaches continued and that there were other breaches.

34 Lancaster Gardens is a service for up to 5 adults with learning disabilities. People were accommodated in two

Summary of findings

bungalows on the same site. At the time of the inspection a service was being provided to three people whose disability was severe and profound and all of whom had communication difficulties and behaviours that challenged. Two people were living in one bungalow and another person was living in the bungalow next door. This was on a temporary basis, while their room was being altered at another location run by the provider organisation.

An acting manager had been in place at the service since January 2015. There was no registered manager at the service; there had been no registered manager since 2 April 2012. 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.

Concerns were raised about the care people received at 34 Lancaster Gardens from the local authority safeguarding team; we responded by carrying out this inspection to assess whether people were receiving safe, effective, caring, responsive and well led care.

Not all risks to people had been recognised and assessed. Action had not always been taken to keep people safe. Risk assessments had not been reviewed and changed to make sure they were up to date and accurate. Regular checks of emergency equipment and systems had not been completed.

Staff knew how to recognise some of the different types of abuse and said they would report any concerns to the manager. They did not know how to report abuse to other agencies outside of the service. The manager did not understand their role in safeguarding and the provider had not reported all allegations of abuse to the local authority.

Restraint was not used appropriately and was not monitored to make sure it was used in line with legislation. People's consent to the use of restraint was not sought or recorded.

There were enough staff on duty to meet peoples assessed needs and recruitment checks were carried out to make sure staff were suitable to work with people.

Staff did not have the competencies and knowledge to meet people's needs and deliver care in the way they needed them to. Staff did not always have an induction and they had not all completed the required training.

Care plans and behaviour plans were not up to date and information was held in different places so was not easy to find. Despite the care plans being recently reviewed, information was not always accurate and did not reflect changes in people's needs. Staff were following conflicting and out of date information.

Medicines were kept safely and administered correctly. Recommendations from health and social care professionals for referrals to the positive behaviour support team were not followed up. Health action plans were not up to date.

The provider did not make sure that people felt that they mattered and practical action was not always taken to relieve people's distress.

People's nutritional and hydration needs were met but were not always monitored effectively.

People were not always involved in assessments of their needs and the planning of their care. Care plans did not include information on what people could do well or what their personal goals were.

People were not involved in decisions about the service and were not always treated with dignity and respect. People's decisions about what they had to drink and when they had a drink were not always respected.

People were not supported to make a complaint. The complaints process was not in a format people could understand.

The service was not well led and the staff lacked the direction and support they needed to meet people's needs and provide care safely.

When people lacked the capacity to make decisions the provider did not always follow the principals of the Mental Capacity Act 2005 to make sure that any decisions were made in the individual person's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some DoLS applications were needed and had been made.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

Staff were not aware of who to report abuse to outside of the organisation. The provider had not always reported incidents of potential harm and abuse.

Risks to people were not always recognised and assessed.

Fire procedures and equipment had not been checked. Plans were not in place to support people to leave the building safely in an emergency such as a fire.

There were enough staff on duty to meet peoples assessed needs.

Checks were made to make sure staff were suitable.

People's medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective

Staff did not have the supervision and training to meet people's needs

Staff did not understand the requirements of the Mental Capacity Act 2005.

Staff were not trained In the use of restraint and on two occasions the restraint used was excessive.

People's health needs were met. Referrals were not always made to the relevant professionals for extra support.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not take action to relieve people's distress and discomfort.

People were not always offered choices in a way they understood.

People were not always supported to make decisions in a way they understood.

Staff did not always ask questions in a way that people understood and did not always give people enough time to respond.

People were not supported to access advocacy services when they needed to.

Is the service responsive?

Inadequate

The service was not responsive

People were not always involved in the planning of their care.

People's needs were not always assessed, recorded and reviewed.

Summary of findings

Care plans did not detail how people's care and support should be delivered safely.

People could not access or understand the complaints procedure.

Is the service well-led?

Inadequate

The service was not well led

The provider did not assess risk and monitor the service effectively. No action had been taken to rectify the shortfalls identified.

Staff were not aware of the vision and values of the organisation.

Staff did not have the direction or support they needed to deliver safe care.

There was no registered manager in post.

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Detailed findings

Background to this inspection

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

This inspection took place on 23 March and 15 April 2015 and was unannounced. The service was inspected by one inspector and a specialist advisor whose specialism was learning disabilities and behaviours that challenge.

We usually ask the provider for a Provider Information Return (PIR). 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. We carried out this inspection at short notice so we did not ask for a PIR.

Before the inspection we looked at all the information we held about the care people received along with information from the local authority and safeguarding team. We looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about significant events which the provider is required to tell us by law.

The three people who used the service were not able to tell us about their experience of the service so we used observations throughout the inspection to engage with them. We spoke with the head of care, the acting manager and three members of staff including an agency worker. People's relatives or visitors were not available to speak to us. We had information from and spoke with, local authority case managers, commissioning officers community nurses, speech and language therapists, occupational therapists and the safeguarding team. We looked at records relating to two care staff, two care plans, medication records, staff rotas, training records, and policies and procedures.

The last inspection was conducted on 7 and 11 August 2014 when we found improvements were needed to meet regulations relating to care and welfare of people and supporting staff.

Is the service safe?

Our findings

People were not able to tell us if they felt safe so we spoke to people's representatives and made observations which showed that people were not always safe.

Staff were able to tell us what some types of abuse were but were not aware of who to report abuse to outside of the service. One member of staff said "I did not know I could contact a safeguarding team I thought, if I saw something, I just reported it to the manager". The manager was not clear about their responsibilities relating to safeguarding, reporting and investigations. The safeguarding policy had out of date contact numbers for the local authority safeguarding team, so if staff used the policy they might not get through to the right person. Staff told us that they had not received training on safeguarding people and the training records confirmed this.

Staff used physical intervention and restraint. On two occasions the restraint used was excessive and not in line with best practice guidance. This placed people at risk of harm. The incidents had not been reported to the local safeguarding team to consider and investigate.

The provider failed to protect people from the risk of harm. This was a breach of Regulation (13) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection we had been informed of an incident that affected two people when travelling in the same car. Staff took action after the incident to keep people safe by seating them away from each other in the car. At the time the head of care (area manager) informed us that, risk assessments had been updated and people would no longer travel in the same car to avoid further incidents. We asked to look at the new risk assessments but they were not at the service. People were still traveling together in the car and were seated in the same seats they were in when previous incidents occurred. Staff and the manager were not aware that people should no longer travel in the same car together. They were not aware of the updated risk assessment and how to reduce risks to people.

There was a risk that people might become anxious and upset when in the car, if their usual route was deviated from by the driver. This risk had not been assessed and managed as not all the staff were aware of the risk and how to minimise the risk by always following the same route.

People did not always understand risk and needed support from staff to understand risk taking as well as how to keep safe. Staff did not have all the information and guidance they needed to manage people's risks and to give the required support, because not all risks had been assessed.

One person was at risk when they went out. This risk had not been assessed. There was no plan in place for staff to follow to reduce the risk. Some people were at risk of financial abuse as staff looked after their money and this risk had not been assessed.

Emergency evacuation plans were not in place for each person. Staff gave different descriptions of the action they would take if there was a fire. We were told that the fire risk assessment was not held at the service so it would not have been made available to the fire service in an emergency. Regular fire safety checks had not been completed. Staff were unsure about how to safely support people to leave the building in an emergency.

The provider had failed to make sure that risks had been assessed and managed to protect people from harm and ensure their safety. This was a breach of Regulation (12) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed for the amount of staff support they needed. This might be on a one to one basis or more. During our inspection there were two staff supporting one person so there were enough staff on duty to meet the person's assessed needs. Agency staff were used to cover any shortfalls. Extra staff were available when needed to support people's needs.

The provider's recruitment and selection policies were followed when new staff were appointed. Staff completed an application form, gave a full employment history, and had a formal interview as part of the recruitment process. Written references from previous employers had been obtained and checks were made with the Disclosure and Barring Service (DBS) before employing any new member of staff to check that they were of good character. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Not all staff files contained confirmation of qualifications.

Medicines were handled appropriately and kept safely. All medicines were stored in locked cupboards in people's rooms. People's medicines had been reviewed by their

doctors and any changes to medicines had been documented. Signatures of staff who administered medicines were at the front of the medicines administration record (MAR) folder so responsibility for the administration of medicines could be monitored. People's photographs were at the front of their MAR chart so that they could be identified as the right person before receiving their medicines. There were systems in place to administer 'when required' (PRN) medicines. The agreement of a senior member of staff was required before they could be administered.

Is the service effective?

Our findings

People were not able to tell us about the service they received so we spoke with their representatives, professionals involved in people's care and made observations, which showed that not all staff had the skills and knowledge to support people, help them to make choices or meet their needs in the way they preferred.

There was an induction for staff but not all staff had completed an induction. Agency staff were used to cover staff shortfalls on a regular basis. Agency staff did not work on their own until people knew them well. Agency staff told us that they had not received an induction.

The service used agency staff on a regular basis to cover staff shortfalls. However, due to people's disabilities, agency staff could not work on their own until people knew them well. Agency staff told us that they had not been supported to get know people. They told us "I have not really been shown what I am supposed to do". There were no records of an induction process for agency staff at the service. We asked the manager if there was an induction process for agency staff and they told us that agency staff were shown around the service and fire exits were pointed out.

After the inspection the provider sent CQC records of the 'agency staff orientation'. Agency staff needed to sign the record to say they had had a tour of the building and had information about, fire procedures, safeguarding, whistle blowing and confidentiality along with having read information about people. There were 49 agency staff included on the sheets and 29 had not signed to say they had completed this process. New agency workers had been included on the sheets up to 27 February 2015. At the inspection, the agency staff member told us that this was their second shift at the service. They said they had not had an induction. They said they had briefly seen a care plan but some information 'wasn't clear or was missing'. They told us they had not been given any guidance on what people's daily routines were.

Staff training had not been planned and developed to make sure that staff had the skills they needed to provide care safely. Training records showed that five out of six staff had not attended fire awareness, moving and handling and infection control training. Training records highlighted when some of the staff training was due but did not show if training had been organised. The manager and staff were not aware of any training that had been organised.

The training record showed that training in supporting people who became anxious and had behaviours that challenge was a requirement for all staff. Not all staff had completed this training.

People had communication difficulties and could not communicate their needs verbally. Staff had not been trained on alternative ways of communicating with people. Some people had communication aids. Staff did not use people's communication aids consistently. We observed that one person became agitated. Staff did not communicate with the person in the way that was recommended in their behaviour support plan. The person's agitation increased because the staff did not have the skills to communicate with the person.

The manager told us that staff should receive monthly supervision and a yearly appraisal. They said that they had not yet conducted any supervision meetings with staff as this was conducted by the head of care for the organisation. There was no record of staff supervision meetings since August 2014. Staff told us they had not received regular supervision and that they did not feel supported by the provider to deliver appropriate care to people. One member of staff said "We are not kept up to date with any changes that we should be aware of".

The provider had failed to make sure staff received appropriate training, professional development and supervision to ensure care was delivered safely and effectively. This was a breach of Regulation (18) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and staff told us that restraint was not used at the service. However, restraint had been used. There had been two incidents when staff who were untrained in the use of restraint had used restraint. The use of restraint had been recorded in a person's daily reports on two occasions and records showed that the restraint used had been excessive. Daily notes recorded that on one occasion a person's hands were held down by their wrists for 10 minutes and on another occasion their hands were held down for 'less than five minutes then the behaviour stopped'.

Is the service effective?

The use of restraint had not been risk assessed and there was nothing in the care records to say people had agreed to the use of restraint or that a best interest's decision about the use of restraint had been made. People had not been involved in the decision about the use of restraint and had not consented to its use. After these incidents there was no record of any action taken to check the person was not injured and to review the circumstances of the restraint to make sure it was not excessive.

People were not protected from the improper use of restraint. This was a breach of Regulation (13) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by making sure if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Some people were under constant supervision and so had DoLS authorisations in place which were under review at the DoLS office. The authorisations were not on the premises and staff were not aware of any review date and conditions.

Staff did not fully understand the requirements of the Mental Capacity Act 2005. The staff were not all clear who could make decisions on behalf of people. Not all the staff had attended training in mental capacity and consent. Capacity assessments had not been completed for everyone so staff might not be clear about people's ability to consent. This was a breach of Regulation (11) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People had health action plans. These were not all up to date. There were instructions from a dietician which stated fizzy drinks should be restricted to three per day. This conflicted with later advice from the dietician which stated that the drinks should not be restricted. Some staff continued to restrict the drinks as they were following out of date guidance.

People had been supported to attend appointments with their GP when they needed to and had regular checks with the dentist. Care records did not show how to recognise if a person became unwell or how they indicated that they were in pain.

Health and social care professionals also told us that on several occasions they had recommended some people should be referred to the local positive behaviour support team. They told us that this had not happened. Staff said that one person had not been referred because they would be leaving the service so no support would be needed. However, the person was still living at the service and needed the extra support. When we looked at care records we saw that no referrals had been made.

People had access to the kitchen and were supported to make drinks, meals and snacks at regular intervals during the day. Advice was sought from a dietician when one person needed to gain weight. The advice was to give the person what they wanted, when they wanted it. This person chose to have a pie for breakfast and this was provided. If people did not want a meal they were offered something else later.

Is the service caring?

Our findings

People were not able to tell us if the staff were caring so we spoke to people's representatives and made observations which showed that people's needs were not always met in a caring manner.

People were not always regarded with kindness, dignity and respect. The way daily notes were written was not always respectful and did not always protect people's dignity. Some phrases the staff had used were negative about people including, 'I can prepare small snacks, I may refuse, just because I prefer someone to do this for me". One person was described as 'in their bad mood'. Daily notes included negative comments such as, 'was/ was not compliant' and described instances of behaviours that challenged as 'attacks'.

People's needs were not always met in a caring way. One person indicated that they wanted the television on in the lounge. They were enjoying using the buttons on the remote control to control the channels. A member of staff took the remote control from them saying "That's boring let's put something on you enjoy". The person immediately became anxious and agitated. The person repeatedly indicated that they wanted the remote control, but this was ignored by the member of staff. Instead they focussed on the person's self-injurious behaviours. Action was not taken to relieve the person's distress. The person's behaviours escalated and they started to display other behaviours that challenged. The member of staff did not recognise that they may have contributed to these behaviours. They did not acknowledge that the person was enjoying having control over the television. The manager said there was no reason why the person could not use the remote control and there was nothing written in their care or behaviour plan to suggest they could not have control of the television.

Staff did not always make people feel that they were listened to and that their choices were valued. A person was enjoying interacting with the inspector. Staff made a drink for another member of staff and for the inspectors. They did not ask the person if they would like to help or if they wanted a drink. The person indicated that they were interested in the drinks by trying to pick up the hot cups. The member of staff then asked them "Do you want a drink, do you want a coffee, do you want a drink?" The staff member did not recognise that the person needed time to process what was being said or that the person may have been indicating that they wanted to help to make the drinks. The staff member did not use the person's communication aid. When the person did not respond, the member of staff walked away, rather than explore what the person was trying to communicate. The person became upset and stopped interacting with the staff and the inspector.

There were missed opportunities to make sure people were actively involved in making decisions about what happened in their home. We were told that there were plans to change the environment and staff said this would cause some disruption and a major change to the service in the near future. Although staff told us that advocates had been used in the past, no new referrals had been made to help people to prepare for the impact of the changes, or to support people to share their views.

People's privacy was maintained. Personal, confidential information about people and their care and health needs was kept securely. Staff wrote notes in people's care plans in the dining room or office and plans were put away when they had been completed. Care was given discretely and staff respected people's privacy. People were asked if it was 'ok' before providing their care. We observed one person being supported to make drinks. The person often overfilled the cup but was encouraged by staff to continue in a positive manner, whilst the member of staff discreetly placed paper towels around the area of spillage. During the activity the person was given lots of praise and encouragement. The person had the opportunity to develop the skills they needed to make their own drinks.

Most staff knew the people they were caring for well and were aware of their personal histories. We observed that people responded positively to staff most of the time. Staff were positive about people's daily achievements. One daily note entry stated, "The person got involved in cooking, went out for a trip out and was in a lovely, happy mood. They had a terrific day." We observed that

one person wanted to go shopping; staff encouraged the person to get ready in a positive manner by confirming "We are going shopping to buy some shoes" and "Shall we get your coat now?" whilst directing the person to their room to get their coat and shoes. The person was not rushed and enjoyed getting ready to go out at a pace that was comfortable for them.

Is the service responsive?

Our findings

People were not able to tell us if the staff were responsive to their needs so we spoke with people's representatives and made observations which showed that staff were not always responsive to people's needs.

Care plans were not written in a way people could understand and there was nothing to say how people were involved in the planning of their care. Care plans included some likes and dislikes but did not include any guidance on what people were good at or what personal goals they had achieved. Records sometimes lacked detail on how people liked their personal care delivered such as, how long they liked to stay in the bath or in what order they preferred to do things like clean their teeth first or have a wash. Records showed that one person often refused to clean their teeth or brush their hair but there was no guidance on what approach should be used to follow this up so the person could have the right support later.

Some information in care plans and behaviour plans had been written using technical language. Staff found this difficult to understand and follow. One plan we looked at was designed to stop the person from having to use behaviour to communicate. The recommendations were not applied correctly or consistently as they were too broad, and open to interpretation, such as 'keep the person engaged throughout the day'. The plan did not say how the person was to be kept engaged and for what length of time each activity should last.

A behaviour plan review in October 2014 noted that some staff had received instruction in a technique to engage people called 'Active Support'. Active support is a method of delivering person centred support by structuring meaningful and purposeful activities into easily achievable steps which match people's level of ability. There were no written directions in the care records to describe how to put this into practice and there was no record of staff having received any training in this method of intervention. We saw the manager using this method throughout our inspection but other staff did not put it into practice.

People had not been involved in assessments of their needs. Each person had a care plan but the way people were involved in developing and reviewing care plans was limited. Some information about meeting people's needs was not included in their care plans.

The provider did not make sure that the design of care ensured that people's needs were met or that they were involved in the planning of their care. This was a breach of Regulation (9) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A review of every care plan had taken place on 12 January 2015 and they had not been reviewed since then. This review had not picked up changes in people's needs, so care plans were not up to date. Some of the risk assessments referred to people who no longer lived at the service and these people had moved out before the review date. A care plan highlighted that when one person displayed certain behaviours that challenged they should be 'removed from the area to protect other service users'. This was no longer necessary as there were less people using the service so circumstances had changed. The care plan and risk assessment had not been reviewed and updated.

There were different folders in use which contained the same information. Some important information such as risk assessments were not included in the folders. There were several entries in the care plans that instructed staff to refer to the behaviour support plans. The information staff needed was not in the behaviour support plans and this caused confusion for staff about how people should be supported safely and consistently.

Care plans stressed the importance of a consistent approach by staff due to people's needs. One person's behaviour plan recorded that the person had difficulty in coping with change and that their care and support should be consistent. The guidance said that their communication aid should be used to plan their day and to explain any changes to avoid any anxiety. On the morning of the inspection we were informed that due to unforeseen circumstances a member of staff would be late so the manager was providing one to one support to the person. There was also an agency staff member present. The manager was interrupted by having to answer the phone and complete paperwork and other tasks. The person's communication aid was not used to help the person understand the change to their day and this led to the person appearing more anxious.

Daily notes indicated that not all staff were following the care plans. A care plan about drinks stated that 'I should never be refused a drink or food', and was based on a behavioural assessment that identified this as a trigger for

Is the service responsive?

certain behaviours. The manager confirmed that no one should ever be refused a drink. Records showed that on occasion's people had been refused drinks. The daily notes recorded that a person had been given a drink early in the morning. When they requested another drink they were told to wait. On another occasion a person had been refused the drink of their choice. This had a negative impact on the person as records stated that the person became 'vocal and aggressive', and staff had to 'move away until the person was calm'. Some staff were giving people drinks when they wanted whilst others had recorded that they were concerned that people could, at times, drink excessive amounts and had been restricting drinks. Staff were given conflicting information and guidance about people's drinks.

Denial of particular items was identified as a trigger for a person to become upset. Staff said the person could not communicate their wants and wishes and would often "kick off" regardless of where they were if they were denied items they wanted. The behaviour plan stated that the person 'must be discouraged and needs to be redirected'. How staff should safely discourage them and how the person should be redirected was not explained. Staff who were trying to follow the care and behaviour support plans were unable to maintain consistency due to interpreting what they needed to do and how they needed to do it, in different ways. There were no risk assessments in the care plans and behaviour plans on how staff should manage behaviours whilst out in the community.

Some care plans were not clear. Staff told us that one person's favourite activity was to visit the shop. The care plan showed indicators of when the person may begin to show behaviours such as, making loud noises, jumping and becoming 'fixated with items or drinks' however, these were also described as indicators that the person was becoming excited. There were no further guidelines to tell staff which emotions the person was displaying. There was a risk that staff could misinterpret the person's emotions and focus on managing behaviours rather than allowing the person to express themselves. Staff did not know how to protect the person, themselves or the public when these behaviours occurred.

Care plans included lists of activities. Daily records showed that apart from shopping trips and drives in the car, these were mainly chores such as laundry, putting clothes away and clearing the table. There was nothing to say which parts of these activities people could do and how long they could do them for. Other activities included water play, arts and crafts and music but there was no instruction as to the type of music, what the art and craft activities were or how and where the water play should take place. Staff did not have all of the information they needed to support people to engage in activities in a meaningful way. Staff did not know how to engage people in an activity at an appropriate level or in the way they needed them too.

People were not supported to make a complaint or raise a concern if they wanted to. Staff did not always recognise when people were not happy about something. Staff did not consistently use communication aids. The written complaints procedure was not in a format that suited people's needs. Staff could not describe how they would support someone to make a complaint. There was a complaints policy and procedure on the office, this was not displayed but kept in a folder. The manager said there had been no complaints recorded.

Care was not delivered in a safe way risks to people were not always assessed and the provider did not do all that was reasonably practicable to mitigate such risks This was a breach of Regulation (12) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

Changes had been made following our last inspection but these changes had not been maintained. People were not able to tell us if the service was well led so we spoke with people's representatives and made observations which showed that the service was not well led. Health and social care professionals including a community nurse, psychologist and care managers confirmed that although some of their concerns had been addressed they still had concerns about the quality of care people experienced.

Some audits had been completed. When shortfalls were identified action was not always taken to rectify the shortfalls. Staff were not aware of the vision and values of the organisation. Staff told us that they were not aware of the expectation of their own values and behaviours. An audit conducted on 18/02/2015 stated that 'A vision is needed which staff can be briefed on and work towards. This can then form part of the staff meeting agenda'. This had not been actioned. Staff were in control and did not always offer choices to people and at times made decisions for people. We observed that when people could make decisions about what they wanted to do with their day, staff often made the decision for them. One staff member said "Get you coat on we are going out for a ride", rather than asking the person where they wanted to go.

Staff told us that communication in the service was not always open and that information was not always shared with them in the right way. An audit conducted on 18/02/2015 highlighted that 'sometimes information and feedback from higher management can be slow and on occasions staff can become frustrated when important information comes through the 'grapevine' before official channels'. Staff told us that this was still happening. One staff member said "We are still not kept up to date and informed about what's going on with the service by senior management".

Staff told us that they did not have regular team meetings. The schedule of team meeting dates showed that staff meetings should be held on a monthly basis and this was confirmed by the manager. No staff meetings had been held since January 2015. Staff said "We should have monthly meetings, we had one in January, before that we had one in November 2014. The November meeting was the first one since July 2014".

Verbal handovers were held between shifts. Staff also used a communication book. These focussed on what people ate and drank, their behaviour and about their personal care. One entry said the person refused to eat their lunch. This was not discussed at the handover and was not recorded in the communication book so was not followed up.

People were not involved in developing and improving the service. There were plans to make major changes to the environment which would cause disruption to the service. People had not been included in decisions about these changes. Staff told us that they had not been involved in the recent changes at the service and the planned renovations. One staff member told us that although there had been a staff meeting they felt their concerns and views about how the changes would affect people had not been taken seriously.

An audit dated 18 February 2015 highlighted issues with the whistleblowing procedure. In response, the provider had installed a whistleblowing phone line that was connected to an answer phone. The audit noted that staff needed to leave their details and would be called back. Staff were concerned that this could breach their confidentiality and prevent them from raising issues anonymously. The audit highlighted that this could prevent staff from whistleblowing but no action had been taken to address this.

Checks on the quality of care people received had been completed but no action had been taken to rectify the shortfalls identified. The audit advised that meetings should be held with people and should include specific feedback such as, what they say is good, what can be improved and an action plan should be reviewed and recorded when complete'. In addition, 'people's involvement should be recorded'. People had not been asked for their views, no meetings were held for people and no feedback was sought from people, their representatives or professionals involved in their care. The service had gone through many changes. The provider had not sent out questionnaires or surveys or used any other means of receiving feedback on the quality of service, since the changes had occurred. There was no action plan on what needed to improve and people's involvement in the service was not recorded.

The provider had not built positive links with the community. Staff told us that people did not go to any local

Is the service well-led?

clubs or events. Daily reports showed that outside activities consisted of going shopping or going for a drive. There was no information on what resources people could access locally. The audit completed on 18 February 2015 highlighted that a list of community facilities should be in place, including addresses and photos. This had not been actioned.

Staff did not have up to date information and guidance on how to provide safe care and meet people's needs consistently. Recent reviews of care plans had not identified shortfalls in risk assessments and the inconsistencies in the management of behaviours. Out of date information had not been removed so care plans had conflicting information about how staff should meet people's needs.

Training records were not up to date and included staff who had left the service. Some showed there were 20 staff employed at the service and some showed there were 10. Staff told us and the rota showed there were 6 staff employed to work at the service. The manager did not know what training staff had completed and had not planned staff training and development to make sure that staff had the skills they needed to provide care safely.

The provider had failed to assess and monitor the quality of service. This was a breach of Regulation [17] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been no registered manager at the service since 2 April 2012. This was a breach of the provider's conditions of registration. A manager had been appointed to manage the service on a day to day basis since January 2015 and was present at our inspections. They had gained a National Vocational Qualification (NVQ) at level 3 and told us they had recently applied to start the new Quality Care Framework (QCF) level 5. They had no previous experience of managing a care service.

The manager was on duty on a daily basis and staff told us that they were approachable. However, the manager said she felt unsupported by the organisation. They told us that they had not had an induction into management. The manager had not been supervised, monitored and assessed by the provider or senior management to check that they had the right skills and knowledge to manage and support staff in meeting people's needs effectively. They told us they had asked for support but this had not been forthcoming. We saw that they were unsure on how to direct staff and provide them with support to meet people's needs safely. They said they had not been supported to develop their knowledge to an appropriate standard or been shown all the processes and protocols for managing the service. They said they felt "poorly supported". They did not have information on how the service needed to improve and could not make sure changes had been actioned. The manager was not fully aware of their responsibilities including implementing the safeguarding policy. Lessons had not been learned from investigations and they had not been used to improve the quality of the service. Support from senior management to the manager had been limited.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not make sure that the design of care ensured that people's needs were met or that they were involved in the planning of their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not fully understand the requirements of the Mental Capacity Act 2005. Staff were not all clear who could make decisions on behalf of people. Not all the staff had attended training in mental capacity and consent. Capacity assessments had not been completed for everyone so staff might not be clear about people's ability to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to make sure that risks had been assessed and managed to protect people from harm and ensure their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from the risk of harm. People were not protected from the improper use of restraint.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to assess and monitor the quality of service.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to make sure staff received appropriate training, professional development and supervision to ensure care was delivered safely and effectively.