Avocet Trust

35 Priory Grove

Inspection report

35 Priory Grove
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Ratings

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

Overall summary

This inspection was unannounced and took place on 13, 18 and 19 August 2015. This was the first inspection of this service.

35 Priory Grove is registered to provide care and accommodation for a maximum of 4 people who have a learning disability and may be living with dementia. The home is a purpose-built bungalow, with four bedrooms, two toilets and one bathroom. It has a large communal area and a garden to the rear.

The service had a registered manager at the time of our inspection. 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.

We found the registered provider was in breach of four regulations of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. These were in relation to person-centred care, safeguarding people from abuse and improper treatment, obtaining consent and working within the requirements of the Mental Capacity Act 2005, and assessing and monitoring the

Summary of findings

quality of service provision. We have deemed these breaches to have a moderate impact on people who used the service. We also found a breach of Regulation 18 of the Care Quality Commission [Registration] Regulations 2009 for non-notification of incidents.

Systems used by the registered provider to assess the quality of the service were ineffective. A quality monitoring programme was in place, however shortfalls in the level of service were not highlighted; therefore action was not taken to improve the service as required.

During the inspection we witnessed an episode of poor and inappropriate care whilst staff were attempting to support someone with personal care. When we spoke with the registered manager it became apparent they were aware of how the care was delivered and had failed to take appropriate action.

The registered manager and staff had completed training in relation to the Mental Capacity Act 2005 [MCA] but it was clear their understanding of the need to have appropriate consent in place was lacking. Decisions had not been made in an appropriate best interest forum and in accordance with current legislation, to ensure people received care and treatment that was in their best interest.

A number of healthcare professionals were involved with the care and treatment of the people who used the service. However, we found that advice and guidance had not been incorporated into support plans and risk assessments which put people at risk of receiving ineffective and inappropriate care.

We found evidence to confirm people's support plans and risk assessments were no longer accurate and did not reflect their current needs.

Staff told us they had completed an in-depth induction process, a range of training and that they received appropriate support and guidance during supervisions and annual appraisals. The registered provider's training matrix provided evidence staff had completed training in areas such as moving and handling, health and safety, dementia and the safe handling of medication. The registered manager told us staff had also undertaken a nationally recognised qualification in care.

Medicines were managed safely. The registered provider had policies that provided guidance on the safe ordering, storage, administration and destruction of medication. We observed staff administering medication; we noted it was done patiently and staff explained what the medication was and the reason the person required it.

Relatives we spoke with told us the staff who supported their family member were kind and attentive to their needs.

People were supported by suitable numbers of staff who had been recruited safely. Before prospective staff commenced working within the service, checks were completed to ensure they were suitable to work with vulnerable people.

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?

The service was not safe. People were not protected from avoidable harm and the poor care practice witnessed during the inspection was reported to the local authority safeguarding team to investigate.

People were supported by suitable numbers of staff who had been recruited safely.

People received their medicines as prescribed.

Requires improvement

Is the service effective?

The service was not effective. Consent to care and treatment was not gained in line with legislation and guidance. The principles of the Mental Capacity Act 2005 were not followed.

People were supported by a range of healthcare professionals and had access to a range of services to meet their assessed needs. However, professional advice and guidance was not always followed.

Staff had completed relevant training pertinent to their role, however they did not always implement within their practice.

People were supported to have sufficient amounts to eat and drink.

Requires improvement

Is the service caring?

The service was not always caring. During the inspection we witnessed a poor episode of care. Staff told us the poor care practice we witnessed occurred regularly.

Staff knew people's life histories and preferences for how care and treatment was to be provided.

Requires improvement

Is the service responsive?

The service was not responsive. The support plans and risk assessments in place did not reflect people's current level of needs.

People were not given appropriate support and care to meet their needs.

A complaints policy was in place at the service which was available in an easy read format.

Requires improvement

Is the service well-led?

The service was not well-led. A registered manager was in place, however they lacked awareness of the principles of Mental Capacity Act 2005 and what constituted poor and restrictive practice.

Inadequate

Summary of findings

An ineffective quality assurance system was in place at the service; issues that took place were not escalated to the nominated individual and the board of directors.

Care Quality Commission requirements, including the submission of notifications were not met. Incidents were not reported appropriately or in a timely way.

35 Priory Grove

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.

This inspection was unannounced; it took place on 13, 18 and 19 August 2015. The inspection was carried out by an adult social inspector. On the second day of the inspection the inspector was supported by a member of the local authority safeguarding team.

Before the inspection took place we contacted the local authority commissioning and safeguarding teams for information about the registered service. We also looked at the information we held about the service.

The people who lived at the home had complex needs which meant they could not tell us their experiences. We used a number of different methods to help us understand the experiences of the people who used the service including the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with two people's relatives. We also spoke with the registered manager, four support workers and two healthcare professionals. After the inspection we spoke with the registered provider's nominated individual.

We looked at people's support plans, risk assessments, pre-admission information and their Medication Administration Records (MARs). We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were deprived of their liberty or assessed as lacking capacity to make informed decisions, actions were taken in line with the legislation.

We reviewed a selection of documentation relating to the management and running of the service; quality assurance audits, the training matrix including the content of some training, board meeting minutes, staff rotas, maintenance records and recruitment information for four staff.

Requires improvement

Is the service safe?

Our findings

A relative we spoke with told us they thought their family member was safe living at the service. They told us, "[The person] is safe; they know how to look after him."

People who used the service were not protected from harm and abusive practices that breached their human rights. We observed staff encouraging one person to go into the bathroom so they could be supported with personal care. The person was screaming and showing obvious resistance to the support staff were trying to provide; this practice was ceased at the instruction of the inspector. A member of staff told us, "It can take between half an hour to over two hours to provide personal care; [The person] will scream and shout" and "[The person] holds onto the doorframe and cries." Another member of staff said, "Every day we have to force [The person] into the shower. One of us takes [The person's] hand's off the door frame and the other one puts their hand on her back and gently pushes [The person] into the bathroom."

The registered provider had a policy and procedure for the use of physical interventions in place at the time of the inspection. The policy stated, "All planned restrictive interventions must be documented in the person's care plan and best interest meeting", "The use of physical interventions should be minimised by the adoption of preventative strategies", "The use of physical interventions must be reported to the Care Quality Commission" and "As soon as practicable after the event, a debriefing session should be organised by the health and safety officer". We found staff had not followed the policy and procedure for physical intervention in their practice. A 'support with shower' support plan was in place for one person which indicated the person required two staff to support them to shower. The support plan stated, "I always stand outside the bathroom by holding the side of the door frame as I don't like to go inside and I scream very loud causing distress to others" and "Staff to encourage me and one staff to lift my hand from the frame and another to put hand on my back to encourage me to walk forward". The registered manager told us physical interventions were used because the person would not go into the shower of their own accord.

We saw a risk assessment in place for one person that described how they could become distressed and be 'aggressive' towards care staff. The risk assessment stated, "Staff to follow the least restrictive intervention policy and to get [the person's] hands/arms down gently to avoid [the person] lashing out." During discussions with staff they told us that one member of staff would hold the person's hands to stop them hitting out whilst the other person would complete personal care. Staff confirmed physical interventions were used every time the person was showered. The use of physical interventions had not been reported in line with the registered provider's policy and no-debriefing sessions had taken place with the health and safety manager.

Daily diary notes provided evidence that on 24 occasions over a two month period it took between 45 minutes and 2 hours and 20 minutes to complete the personal care this person required. As physical interventions were used by staff, the amount of time this person was allowed to be distressed for was excessive and meant they did not receive care and support in an appropriate and compassionate way. A member of staff said, "It's a battle of wills" and "Some days if we have tried for an hour and a half to get [The person] into the bathroom we might decide to give them personal care in their room that day." We reported our concerns to the local authority safeguarding team who are currently completing an investigation into the care and treatment of the person.

Records indicated that staff had completed training in relation to the safeguarding of vulnerable adults. However, in practice staff failed to recognise that allowing a person to be subjected to prolonged periods of distress on a daily basis could amount to psychological and organisational abuse. A member of staff explained, "The first time we had to get [The person] into the shower it took, me, another member of staff and the manager. It was upsetting and stressful for all of us; I questioned the manager and she said it was ok so I have just carried on." Another member of staff told us, "I didn't think it was right and have always thought this isn't working, but the manager had spoken to the OT [occupational therapist] so I thought we were doing the right thing."

Risks to people's health and welfare were not always managed effectively to ensure they received safe care and treatment. A speech and language therapist (SaLT) had assessed one person and advised they needed their food to be of a 'soft and moist consistency' due to the risk of choking. The person's support plan and risk assessment did not reflect this advice which meant the person

Requires improvement

Is the service safe?

remained exposed to the risk. Staff confirmed they had recently become aware the person required a soft and moist diet and confirmed the person was given food of an unsuitable consistency for approximately four months. Similarly, one person used a wheelchair at certain times which enabled them to access the community; a support plan was in place that stated, "Staff to make sure to put the safety belt on at all times to avoid any risk of falls." The registered manager explained that as a health and safety precaution the person who used the service had to have the lap belt on; staff told us the person was highly resistant to the safety belt being used. The service failed to recognise that the continuous use of the lap belt on a person who showed resistance to having it in place was a restriction and a form of restraint and had not followed the MCA or best practice.

Antecedent Behaviour Consequence [ABC] charts were used by staff to record incidents of violent and aggressive behaviour by people who used the service. It was unclear what investigations had been completed in relation to the incidents recorded in them. The registered manager told us, "I put a risk assessment in place so the staff didn't leave them [the people who used the service] alone together." Support plans had not been updated; precursors to the behaviours had not been identified and none of the incidents had been reported to the local authority safeguarding team to enable them to undertake investigations as required. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

Suitable numbers of staff were deployed to meet the assessed needs of the people who used the service. The registered manager told us they were in the process of recruiting new staff due to vacancies in staff team. During the inspection we saw that agency staff were used regularly. The registered manager explained, "I always try and have one of our staff working with the agency staff so the clients are supported by someone they know." A member of staff we spoke with said, "There isn't any problems with the agency staff but it's a lot easier when Avocet staff are working. I think it's better for the clients as well because they get to know us."

We saw evidence to confirm safe recruitment practices were followed by the registered provider. Before prospective staff began working with the service an interview took place, Disclosure and Barring Service [DBS] checks were completed and two references were taken to ensure the person was suitable to work with vulnerable adults. Staff completed an induction process and were matched to a specific service within Avocet Trust on their compatibility with the people who used that service.

Medicines were stored safely. Dedicated medication cabinets were utilised within the service. We saw room temperatures were recorded daily to ensure medicines were stored in line with the manufacturer's guidelines.

Staff had completed training in the safe handling of medication and had their competency assessed before they administered people's medicines. Medication Administration Records (MARs) were completed accurately without omission. We observed staff administering medicines and noted people were afforded time to comprehend staff's action and were given clear explanations regarding the need for the medication. Before any creams were applied, staff put on gloves to reduce the chance of any infections. However, staff put gloves on before they had taken the cream from the medication cabinet which meant the gloves were no longer clean when the cream was applied. We mentioned this to the registered manager who confirmed they would address the issue with the staff.

Requires improvement

Is the service effective?

Our findings

A relative told us, "The staff change a lot but they do seem to know what they are doing."

We found consent to care and treatment was not always sought in line with the Mental Capacity Act 2005 [MCA]. The registered manager and staff did not understand the of the principles of the MCA which lead to people receiving care and treatment that they had not consented to and had not been agreed in a best interest forum.

Daily diary sheets provided evidence that one person who used the service resisted staffs efforts to support them with their personal care needs. Staff spent a disproportionate amount of time trying to encourage the person whilst they were distressed and showed obvious signs of anxiety.

The registered manager told us they had received advice and guidance from relevant professionals and was told providing personal care in the way that was observed, which caused obvious distress to the person, was in their best interest. When we spoke with the relevant professionals involved with the person's care and support they told us that they had provided guidance to the registered manager that a least restrictive approach was required. They said they had given advice regarding what support would be the least restrictive, less distressing for the person and still met their personal care needs. They also said they had informed the registered manager that their advice and guidance would need to be discussed in a meeting with relevant people to ensure a best interest decision was reached.

A best interest decision was not in place for the person which covered the use of physical interventions to provide personal care to them and to ensure the least restrictive intervention was applied. The registered manager told us they believed a best interest decision had been made for the service to provide all of the care and treatment the person required. This would have allowed any changes to the person's needs to be planned for and carried out by staff and would amount to a unilateral best interest decision taking place which would not be in accordance with the MCA and recommended good practice.

Further advice from a relevant healthcare professional included the need for a best interest decision to use the lap belt on the wheelchair if a person showed resistance to it being used. Staff told us one person clearly resisted the use of the lap belt but they had been informed by the registered manager, and it was documented in the person's support plan, that the belt must be used whenever the person used the wheelchair. There was no best interest decision in place for the use of the lap belt which meant that its continued use was a form of restraint.

A risk assessment had been developed for one person who used the service regarding a decrease in their cognitive abilities. It stated staff were to carry out best interest meetings 'when needed. We found evidence to confirm that best interest meetings were not held 'when needed' which meant the care and treatment being provided was not appropriately authorised and was carried out without consent.

Staff and the registered manager had completed MCA and Deprivation of Liberty Safeguards [DoLS] training; they understood how to gain consent when a person lacked capacity but their knowledge of when a best interest meeting was required was lacking. A healthcare professional told us, "We told the manager that a [best interest] meeting needed to be arranged for [the person].

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

During the inspection and after prompting by us the registered manager called an emergency best interest meeting to ensure that the least restrictive interventions were used to provide personal care and the use of physical interventions were agreed and a best interest decision was reached. After the meeting took place a new support plan and risk assessment were produced incorporating the best interest decision and provided guidance for staff which ensured the person received support with the least restrictive interventions.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities in relation to DoLS and was in the process of making applications to the supervisory body to ensure the people who used the service were not deprived of their liberty unlawfully.

Requires improvement

Is the service effective?

Staff told us they had completed a range of training including, 1st aid, infection prevention and control, fire safety, safe handling of medications, safeguarding of vulnerable adults, health and safety, epilepsy and an accredited 'management of aggression' course. The service's training matrix provided evidence to confirm that staff's training was up to date. The registered manager told us, "After speaking to a dietician, it was decided that the staff would benefit from doing nutrition training. Our clients may need supplementary drinks or high calorie diets so we thought it was best to do the training now." The registered manager also stated that all Avocet Trust care staff have to complete a care certificate diploma to increase knowledge and for personal development.

We saw evidence that staff received on-going training, support and professional development. Supervisions were used to explore staffs development opportunities and to ensure they carried out their roles effectively. One member of staff told us, "We have supervisions about every six to eight weeks; the manager is helping me to develop because I want a senior post." The registered manager told us that staff's yearly appraisals were due to be completed within the next four weeks.

People were supported by a range of healthcare professionals; we saw that community nurses, occupational therapists, dentists, GPs and dieticians, speech and language therapists, psychologists and physiotherapists had contributed to people care and treatment. However, we found that professional advice and instructions were not always implemented effectively. Advice from a community nurse and occupational therapist in relation to least restrictive interventions were not followed. Written instructions from a speech and language therapist had not been considered when a person's support plan and risk assessment were produced; which increased the risk of a person choking.

People received a varied and balanced diet. We observed staff preparing meals for people accommodating their choices and preferences. A member of staff said, "It can be difficult to know what people like to eat when they can't communicate with you, we just have to try certain things and if they don't like it we try something else." Plate guards and specific coloured plates and mugs were used to help people maintain their independence with eating and drinking. Records showed people were weighed regularly and staff told us they would contact a dietician if people lost or gained weight consecutively over a three week period. This helped to ensure people remained at a healthy weight.

Requires improvement

Is the service caring?

Our findings

When we asked one person who used the service if they were supported by caring staff, they responded positively. When we asked the person if they liked the staff who supported them, they responded positively and told us, "Yes."

A relative we spoke with confirmed they thought their family member was supported by caring staff. They told us, "[Name] is happy and settled; the staff are very caring." Another relative said, "It never seems like staff are going through the motions, they all seem to genuinely care."

We observed poor care being delivered where one person was clearly distressed and staff failed to react appropriately to the person's needs. Staff did not respond to the person's attempts to communicate that they did not want the support offered by staff. Staff told us the person reacted in this way on a daily basis and they would often scream and cry for up to two hours during attempts to provide personal care to them. A member of staff told us, "I have never liked doing it but that's why the manager got other professionals in because it was such a difficult situation. I did know it wasn't right, no matter what anyone said." Another member of staff told us, "I don't like forcing [the person] to do something they don't want to do, I didn't like seeing [the person] so upset." and "I wouldn't like it to happen to my Mum."

During the inspection it was clear staff knew how to support people and we observed people who used the service actively seeking the attention of staff. Interactions between staff and people who used the service were positive with the exception of the delivery of personal care to one person who used the service.

Staff were aware of people's life histories and knew their preferences for how care and support were to be delivered. Information such as where people grew up, family histories and important people in their lives was recorded in their care plans. Staff told us about activities people enjoyed and how they related to aspects of their lives before they moved into the service.

We saw that people were involved in the planning of their care when possible. Families and appointed people we spoke with confirmed that they were asked for their input into the planning and delivery of care. This helped to ensure people were listened to and their views were respected. Picture cards were used within the service to help to convey what support people required. For example, a picture of a toothbrush, a toilet, different foods were used so staff and people who used the service could communicate effectively. A member of staff told us, "If [the person] has an appointment at the doctors and we explain what is going to happen that day, if [the person] does not want to do it then we can't make them, we just respect their choice."

The registered manager told us, "We have not had to use an Independent Mental Capacity Advocate [IMCA] because the families of our residents are so involved; they come to meetings and we speak to them about everything that happens." They went on to say, "We know how to contact one [an IMCA] if we ever need their support."

The relatives we spoke with confirmed that there were no restrictions placed upon their visiting times. The registered manager explained, "Families can come anytime, they usually call and let us know because the clients go out on activities but they can come anytime."

During discussions with staff they described how they would show people respect and uphold their dignity. Comments included, "I always knock on their door before I go in their rooms", "[The person] likes to look nice so I help chose clothes and make sure they are always presentable", "I always try and explain things simply so they can understand", "I try and treat them how I would want to be treated."

The registered provider had a confidentiality policy in place and staff told us they were aware of the importance of not sharing people's private information. Confidential information was stored in the registered manager's office which only authorised people had access to. Records were kept electronically to ensure relevant information was not lost if paper records were damaged in any way or were needed to be duplicated in an emergency situation.

Requires improvement

Is the service responsive?

Our findings

Relatives we spoke with confirmed that they were involved with the on-going planning of their relatives care. One relative said, "We chose the service, the last place [the person] was at couldn't look at [the person] anymore so we met with the manager and decided this was the best place for [the person]." They also said, "I am at every meeting the manager lets me know about, I want to be as involved as I can be." Another relative told us, "I get consulted about [the person's] care; my daughter is always involved with everything that happens."

Relatives told us they knew about the registered provider's complaints procedure and said they would discuss any concerns they had directly with the registered manager.

People had their needs assessed before they moved into the service. The pre-admission assessment was then used alongside the local authorities 'my life, my way' care plan to develop individual support plans to meet people's assessed needs.

The registered manager told us reviews of people's care needs were completed on a six monthly basis unless a change prompted an earlier review; however, we found evidence to confirm reviews of people's care needs had not always taken place. During discussions with staff it became apparent that people's support plans and risk assessments did not reflect their current needs. For example, the registered manager told us one person had been supported to see a dentist who had advised they no longer needed to use their dentures as they were old and ill-fitting. The person's 'oral care' support plan stated, 'I wear dentures but sometimes don't like to put them on. Staff to encourage me to put them on especially at meal times'. The support plan had not been updated and could have led to the person having to wear ill-fitting dentures against professional advice.

A letter containing advice from a Speech and Language Therapist [SaLT] was in one person's file which stated staff were to prepare a person's food to a specific texture. The person's 'nutritional needs' support plan and the 'choking' risk assessment failed to in-corporate the professional advice. The registered manager and staff said they had recently become aware of the need to prepare food to the advised texture but had failed to update the person's support plan and risk assessment. The registered manager admitted, "Plans should be updated straight away if it's urgent but they should always be done after a week or two at the most" and "The time we have had out of date information [in the support plans] is not acceptable."

A support plan was in place which provided instruction to staff when showering one person who used the service. The plan stated the person needed to be showered daily, in the morning. A 'self-neglect' risk assessment was in place which stated the person, 'requires showering daily due to body odours to avoid self-neglect.' The risk assessment failed to take into consideration the amount of time the person was distressed for during staff attempts to provide personal care. During the inspection we spoke with two healthcare professionals involved with the care and treatment of the person; both professionals confirmed that advice had been given to the registered manager stating the person did not need to be showered everyday due to the level of distress it caused the person. Failing to utilise the advice and guidance of relevant professionals contributed to the emotional distress the person suffered on a daily basis and meant staff had not been responsive to their needs. After the first day of the inspection a best interest meeting was held at the inspector's instruction; subsequently the person's support plan was updated to reflect the advice and guidance that had been given previously by professionals to the registered manager and was reiterated at the best interest meeting.

One person had a 'communication' support plan in place that stated they had limited verbal communication skills but could say 'yes' or 'no'. The plan did not include any non-verbal communication methods used by the person such as facial expressions or gestures. The care plan lacked insight into the person's communication needs and failed to provide guidance for staff to ensure they could communicate with the person effectively.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

Reasonable adjustments had been made to the building to support people's identified needs. Metal carpet strips used in doorways had been removed as they were highlighted by a relevant healthcare professional as a possible issue for one person who used the service. Stepping over thresholds has been proven to cause issues for people living with dementia. Bright colours had been painted around light

Requires improvement

Is the service responsive?

switches to help people identify them and toilet seats were a bright colour which made them easier to identify and helped people to remain independent. The registered manager told us, "This is a purpose built home, it has wide corridors and door openings to make things easier for wheelchair users; we have bath hoists and other equipment that makes things easier for people."

The registered provider had a 'compliments, comments and complaints' policy in place. An easy read version had been developed to make the process more accessible to people who used the service. A member of staff told us, "We haven't had any complaints that I know of, we speak to their [the people who used the service] families all the time though so if anyone had a problem I'm sure they would tell us." The records we saw confirmed no complaints had been received by the service.

The registered manager told us they encouraged relatives to provide feedback on the service whenever possible. They told us, "When anyone has been complimentary, we ask them to record it. I use any compliments to keep the staff motivated and to make sure they keep up their hard work."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. There was a registered manager in post who had registered with the Care Quality Commission [CQC] to manage the service. However, the service was not managed effectively, we found numerous concerns during the inspection and breaches of regulations 9, 11, 13 and 17 which we deemed had a major impact on the people who lived at the service. Regulation 18 of the registration regulations had also been breached.

When we spoke with staff about the support and guidance they received from the registered manager their responses were mixed. Some staff were positive and commented, "She is approachable, you can always ask her anything", "She is constructive and she tells you how she wants things done; she does not mince her words" and "The manager is good, she is knowledgeable and she gets advice when we need it. I do wish she was here more though." However, we were also told, Comments included, "You can't question the manager" and "The manager does not listen",

The registered provider had a quality assurance system in place that consisted of audits, checks and questionnaires. We found evidence that the system was not utilised effectively which meant that incidents of poor practice or safeguarding concerns were not reported to the CQC, the local authority safeguarding team or the registered provider's board of directors or Nominated Individual.

A 'monthly compliance form' was completed by either the registered manager or a manager from another of the registered provider's services. The 'monthly compliance form' was divided into seven sections. These covered, mandatory regulation, health and safety, medication, clients, staff, housekeeping and interior and outside. Each section had a number of questions that checked if specific things were in place and a rating could be assigned to each question from one to four. The registered manager told us they were in the process of updating the registered providers care plans and policies and procedures so the 'monthly compliance form' had not been completed as regularly as expected.

We saw evidence that audits were completed in June 2015 and areas such as 'client individual risk assessments', 'clients care plans' and 'record of best interest meeting' had been ticked to confirm they were rated as 'good'. The auditing system used had not identified that care plans and risk assessments failed to reflect the person's current needs and that the best interest decisions in place did not cover aspects of care and treatment people were receiving that they had not consented to.

The auditing system had failed to identify that staff had recorded over 20 occasions in a two month period that it had taken between 45 minutes and over two hours to provide personal care to one person who used the service or that the person had shown obvious signs of distress throughout these episodes of care. The auditing system had not been effective in ensuring the poor episodes of care were escalated appropriately in line with the registered provider's policies or that the episodes of care were stopped. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response and will report on any action once it has been completed.

On the first day of the inspection, we found records completed by staff which detailed a number of incidents of people who used the service having aggressive and challenging behaviour; these had occurred within the service during July 2015. The registered manager told us, "I have seen the incidents; I put a risk assessment in place to stop them from occurring again." On the second day of the inspection we saw that the registered manager had spoken with staff and one of the records had been changed. We asked the registered manager to explain why the record had been changed when the incident had occurred a month earlier. The registered manager told us, "They [staff] hadn't recorded what had happened properly; when I spoke to them it was clear what they had written had not actually happened." This meant inaccurate recording occurred within the service.

Incidents of possible harm or abuse had not been reported to the local authority safeguarding team or the CQC as required; it is a legal requirement for us to be notified about these events, so that we can monitor services effectively and carry out our regulatory responsibilities. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2009. We are currently considering our regulatory response and will report on any action once it has been completed.

After the inspection was completed, we spoke with the registered provider's nominated individual. They told us, "We need to look at what has happened and why things

Inadequate

Is the service well-led?

have gone wrong" and "I got professional support for the service so thought things were ok; I didn't know they were having problems like this." The registered provider's system for escalating issues within the service was ineffective which led to people receiving inappropriate care and treatment and safeguarding concerns not being reported.

The nominated individual described the process for reviewing incidents that took place within the service; they told us they would review each incident and make recommend actions to improve the care and treatment people received. However, we saw that the nominated individual was not aware of all of the incidents of challenging behaviour that occurred within the service.

The registered manager told us they worked closely with healthcare professionals to ensure people received safe care and treatment. They also said, "The service manager sends NICE [National Institute of health and Care Excellence] guidance to all of the [registered provider's] registered managers so we can take any actions that's required." We saw the registered provider's auditing systems and policies and procedures were currently being reviewed and updated. The registered manager told us a quality assurance board was to be developed and they would review monthly quality assurance reports from each service.

The registered provider had a 'whistle blowing' policy in place. The policy contained at hotline number which meant staff could report any concerns they had. A member of staff told us, "I know about the hotline, our chief executive talks about it during our induction." We asked staff if they considered 'blowing the whistle' on the practices which had occurred within the service; they told us even though they did not agree with the way personal care was provided and did not like carrying out the tasks outlined in the support plans and risk assessments, they had not considered 'blowing the whistle'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Person -Centred Care. How the regulation was not being met: People who use services were not protected against the risks associated with inaccurate and out of date care plans. Regulation 9 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Need for consent. How the regulation was not being met: People who use services were not protected against the risks associated with receiving care and treatment they had consented to or which had not been agreed in a best interest forum. Regulation 11 (1)(2)(3)

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 Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse and improper treatment. How the regulation was not being met: People who use services were not protected against the risks associated with receiving abuse and improper treatment. Regulation 13 (1)(2)(3)(4)(b)(6)(b)(7)(a)

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Good governance. How the regulation was not being met: People who use services were not protected against the risks associated with receiving with failing to monitor the level of care people received effectively. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.