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Bedrock Lodge

Inspection report

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Date of inspection visit:
13 February 2017
14 February 2017
16 February 2017

Date of publication:
10 August 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bedrock Lodge provides accommodation and personal care for up to 11 people aged 18 years and over. At the time of our inspection nine people were using the service.

This inspection was unannounced and took place on 13, 14 and 16 February 2017.

We carried out inspections of three of the provider's locations from 13 to 17 February 2017. These locations are; Bedrock Lodge, Bedrock Mews and Bedrock Court. The reports of all three inspections can be viewed on our website. The provider's main offices are at Bedrock Lodge. We found many aspects of the service provided at the locations to be similar. This is because the policies, procedures, systems and processes used by the provider were consistent across all three locations. In addition, a number of staff worked across all three locations and, until recently the service users from each location attended Bedrock lodge during the day. As a result, each of the three reports contains some information that is similar.

Bedrock Lodge was placed in 'special measures' by CQC as a result of our inspection on 27, 28 and 29 September 2016.

Following this inspection, the overall rating is 'Inadequate'. This means that it remains in 'special measures'. 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.

Full information about CQC's regulatory response to these concerns will be added to reports after any representations and appeals have been concluded.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager of Bedrock Lodge was also the registered provider. The registered manager was not available when we visited. They had been absent from 3 January 2017.

Following the inspection in September 2016 the provider had made arrangements for a 'turnaround team' to oversee the management of the service from November 2016. This had involved the provider commissioning experienced health and social care staff to be available on a day-to-day basis and co-ordinate the management of the service in addition to an independent project manager. They oversaw the senior person from the 'turnaround team' and an acting manager directly employed by the provider, who managed an assistant manager, senior care staff and support workers.

After the inspection in September 2016 some improvements had been made to ensure that people's immediate safety was considered and action taken. Immediate actions included, finding alternative placements for people whose needs were not being met, people from the provider's other two locations ceasing using Bedrock Lodge for day care and staffing levels increasing at night.

Additional improvements were identified and referred to throughout this report. However we were concerned the improvements we saw would not be sustained following the withdrawal of the 'turnaround team'. Staff employed directly by the provider and, members of the 'turnaround team' themselves were unclear how much longer this arrangement would be in place. We wrote to the provider and asked them to provide us with further information detailing their plans for any withdrawal of this additional input. The response we received was vague and they told us a date for withdrawal had not been decided and that plans were yet to be agreed. This raises concerns and, we could not be satisfied, that the improvements we found would be sustained and that subsequent improvements required would be achieved. The inspection history of the service shows repeated concerns regarding keeping people safe and the leadership and management of the service.

Staff told us they were concerned any improvements would be reversed when the 'turnaround team' were no longer in charge and the provider took control. Some senior staff told us they felt they were able to withstand attempts to do this; others felt it unlikely they would be able to do so.

Since the inspection in September 2016, there have been 11 new individual safeguarding concerns raised with the local authority relating to people living at Bedrock Lodge and 35 in total across all three of the provider's locations. The concerns about the service were still considered a risk by the local authority and other agencies, and the service continues to be placed in an organisational safeguarding process.

There had been a slight improvement in identifying risks and providing staff with guidance on keeping people safe. However, staff awareness of these were not consistently good and some risks had not been thoroughly planned for. Measures to ensure the prevention and control of infection were not sufficiently applied.

Staff still lacked the skills and abilities to provide effective care and support. Staff did not always have a good understanding of the principles of the Mental Capacity Act (MCA) 2005 or best interest decision making. However, people told us they were now able to make more day-to-day choices and decisions. Relevant health and social care professionals were now more involved in ensuring people's needs were met. However on occasions staff compromised this process through their lack of knowledge and understanding.

At the inspection in September 2016 we found the provider/registered manager and staff had failed to recognise where certain practices compromised people's dignity and respect. We also reported that the service was, in many ways, demeaning to people and did not contribute towards them being viewed as valued individuals. Although improvements had been made, people were still not always treated with dignity and respect. The improvements made had been led by the 'turnaround team'. People told us they felt they were better cared for and more able to exercise their independence. However further progress will be required to take this forward as the structure and delivery of the service is still more likely to foster dependence than independence, because of the way the service has been previously led and managed.

People still gave the impression of feeling they were required to fit into the service rather than the service being designed and delivered around their needs. In addition, the service had failed to continually assess and support people in ensuring the service was still a suitable place for people to live. The provider/registered manager had failed in their responsibility to engage with commissioners who funded

people's placements to ensure that placements were still appropriate.

The impact on people due to the lack of support and planning to ensure smooth transitions was unsatisfactory. For people who had moved the experience had been disorganised and potentially traumatic. The attitude of staff to other professionals was not always positive. They did not see the professionals' support as helpful and in people's best interests. Although the 'turnaround team' had tried to change this attitude, it was still evident with some staff.

Although staff were making efforts to provide activities that were person centred and supported choice and personal preferences, their attempts were compromised by the provider/registered manager, and this reinforced our previous concerns around the control they exercised.

Since the 'turnaround team' commenced in November 2016 they had needed to prioritise the most urgent areas for improvement in order to keep people safe. Some of the actions they had taken had improved the quality of service people received. This was particularly around improving their day to day lifestyle. People were making far more choices about everyday matters, for example, what time they got up, when they went to bed, what they did during the day, what they ate and drank and when they received meals. They had worked extensively with permanent staff members on role modelling, coaching and introducing best practice.

People told us they felt safer. Staff had a better understanding of how to recognise the possibility of abuse and report concerns appropriately. Staffing levels at night had increased. The management of medicines had improved and people benefitted from revised individual protocols for the administration of these. Some positive changes to the environment had also been made.

Staff had received some additional training to meet people's needs. We did see staff treating people in a more caring manner. People's care records were written in a more objective and positive manner. The turnaround team had tried to build better working relationships with other agencies and to educate staff on the importance of this in order to enhance people's health and well-being.

We found, and have reported on, breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments had been revised and provided staff with guidance on keeping people safe. However, staff awareness of these was not consistently good and some risks had not been thoroughly planned for.

Measures to ensure the prevention and control of infection were not sufficiently applied.

People said they felt safer now the service no longer operated as the base for people from the provider's other locations during the day.

Staff had a better understanding of how to recognise the possibility of abuse and report concerns appropriately.

Staffing levels at night had increased and were sufficient to keep people safe.

The management of medicines had improved and people benefitted from revised individual protocols for the administration of these.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received some additional training to meet people's needs. However, staff still lacked some skills and abilities to provide effective care and support.

The service provided was not in accordance with the principles of the Mental Capacity Act 2005 (MCA).

People were now able to make more day-to-day choices and decisions. They had access to hot drinks or snacks when they wanted them and, were able to choose activities they wanted to do and food they wanted.

Relevant health and social care professionals were now more

involved in ensuring people's needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were still not always treated with dignity and respect.

Staff treated people in a more caring manner and care records were written in a more objective and positive way.

However, overall the structure and delivery of the service fostered dependence rather than independence.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs, wishes and aspirations were not brought together in a plan aimed to meet these. People views and opinions were not always sought when planning their care and support.

The provider had not always worked in co-operation with other health and social care professionals to ensure these moves were as smooth as possible for people.

People had greater freedom over choosing what they did during the day.

Is the service well-led?

Inadequate

The service was not well-led.

The culture of the service was not empowering and person centred.

There was no clear plan for the withdrawal of the 'turnaround team', sustaining improvements or, the provider's plans for the future of the service.

The inspection history of the service shows repeated concerns regarding keeping people safe and the leadership and management of the service.

The registered manager/provider had not taken action to investigate concerns regarding staff.

Bedrock Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 13, 14 and 16 February 2017 and was unannounced. This meant the provider did not know we would be visiting.

The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of services for people with long term mental health needs.

The last full inspection of the service was carried out on 27, 28, 29 September 2016. At that time we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service 'Inadequate' overall and placed it in 'special measures'.

Prior to this inspection we looked at the information we had about the service. This included information of concern shared with us by health and social care. We also reviewed the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Due to the number of individual safeguarding concerns raised regarding the providers services. This location (along with two others managed by the provider) had been under a process of 'organisational safeguarding'. This is a process initiated by the local authority as a result of the number and/or severity of concerns raised with them. CQC had attended meetings prior to this inspection. This meant CQC had been closely involved with a number of health and social care professionals, social workers and commissioners regarding the service. We have referred to the intelligence reports we have received from those that visit the service and from multi-agency meetings we have attended.

During the inspection we spoke with each person living at Bedrock Lodge. We also spoke with a total of eight staff. This included; the acting manager, office based staff, members of the 'turnaround team', support workers and one 'apprentice'.

We looked at the care records of five people living at the service, staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People did not always receive a service that was safe.

At the inspection in September 2016 we found people were at considerable risk. A substantial number of risks were immediately reduced following the inspection. This was attributed to, finding alternative placements for people that should not be living in the home, people from the providers other two locations stopped using Bedrock Lodge for day care and the staffing levels were increased at night. Despite some improvements and positive responses from people around feeling safer, a number of concerns and breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 still remain. In addition there had been 11 new individual safeguarding concerns raised with the local authority about Bedrock Lodge since the inspection in September 2016.

When asked if they felt safe at Bedrock Lodge people gave mixed views. Comments included; "Yes I feel safe. There are people and my friends all around", "Yes I do feel safe, but it is my confidence that is low, the location and the roads are not safe for me to walk out independently", "Yes I feel safe; Some of the people I like, but there is one I don't" and, "No I don't feel safe. I used to be treated nicely, but not here".

At the inspection in September 2016 we found risk assessments were not always in place to keep people safe. Those assessments that had been developed, lacked detail and guidance for staff to follow in order to reduce or prevent risks from occurring. This was particularly concerning as people had significant health and complex behavioural needs. Although we saw some improvements had been made further development was required. We saw a good risk assessment had been implemented for a person who had complex epilepsy. This provided staff with guidance on how to keep them safe at home and when they were out in the community. However we found that some risks to people had still not been identified by staff. One person was at risk of displaying inappropriate behaviour towards people of the opposite sex. Assessments were not in place to enable staff to identify triggers and how to manage this should the problem arise. We also found when we spoke with some staff that they were not aware risk assessments were in place for people in order to reduce risks and protect them.

At the inspection in September 2016 we found people were not kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. We also reported the registered manager/provider had not always raised concerns immediately with the appropriate authorities. Since this inspection staff had received additional training on safeguarding and protecting vulnerable adults. They were now able to tell us what action they would take if they suspected, witnessed or received allegations of abuse.

There had been a significant amount of safeguarding concerns raised to the local authority, police and CQC following the inspection in September 2016. These had been managed through the local authority's individual safeguarding processes and some were still being investigated at the time of this inspection. Although staff had raised some safeguarding concerns, many had resulted from the increased involvement from other health and social care professionals visiting the service. We noted the improvements in

managing safeguarding processes had been led by the 'turnaround team'. Permanent staff candidly told us they felt the registered manager/provider had not tried to build and maintain confidence and trust with the local authority. They had found this to be a continued barrier and in a sense felt that ongoing relationships and effective communication was difficult with the local authority. Considering these factors we cannot be satisfied in the ability of the registered manager/provider to improve relationships in addition to being able to sustain this in the long term and ensure people are kept safe.

Overall we found the home to be generally clean. However a communal toilet on the ground floor was in poor repair and required a deep clean. The toilet basin was loose and not attached to the floor adequately and the mastic seal had come away. The room smelt offensively of stale urine. Furnishings in communal areas looked tired with significant wear and tear. This did not lend itself to safe and effective management of infection control risks. Following our inspection, the provider was able to send us copies of infection control audits that had been completed and, evidence that staff had received training on the control and prevention of infection.

These were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Night time staffing levels at Bedrock Lodge had altered. When we inspected the service in September 2016 one staff member slept in at the service at night and, was responsible for the safety of 11 people with a variety of complex needs. This was not sufficient to ensure people were safe. We saw the night time staffing now consisted of one staff member awake and, one sleeping in. This, in addition to the fact there were now nine people living at the service, gave us greater confidence people could be kept safe in the event of an emergency or as a result of confrontation between people when anxious or distressed. Staff had access to an on call manager by telephone for advice, support or guidance when required. Emergency evacuation plans were in place to guide staff.

Staffing levels during the day were sufficient to keep people safe. Bedrock Lodge was no longer used as the day service base for people using the provider's other services. This meant there were less people at the service during the day. People told us they felt this was better. They said it meant the service was calmer, with less confrontation and, that they were better able to find staff when they needed them. One person told us, "I find it better since the homes are now separated. This now feels more like my home. There were too many people here during the day and not enough staff, and if you had to go to the doctors you couldn't, you couldn't do anything because there were not enough staff". Staff confirmed the changes had made a positive impact on people's safety.

At the inspection of September 2016 people's safety was compromised because apprentices were expected to carry out the full range of duties expected from other permanent care staff. We further found that, considering people's diverse and complex needs 'apprentices' did not have the qualifications, competence, skills or experience for the work they were expected to perform. During this inspection staff and, 'apprentices' themselves, told us this was no longer the case. They said 'apprentices' were no longer providing personal care unsupervised. Staff rotas showed 'apprentices' were additional to the usual staffing levels as would be appropriate for their level of experience.

The recording of the administration of medicines had improved. Records were kept detailing when as required ('prn') medicines had been administered. These recorded how people presented before and after the administration of medicines for anxiety and distress. Staff were able to explain to us the process for administering these medicines. Individual protocols were in place to guide staff on when and how to offer these medicines. For example, one person who was prescribed emergency medicines had a plan in place for

their administration. Staff knew where these were kept and told us the plan for administration of emergency medicines was taken with the person when they went out. Staff knew what action they must take in the event of any errors in the administration of medicines. They told us how they would get medical advice or assistance and report the error to the local authority safeguarding team.

The condition of the physical environment both in the home and its grounds had improved since our last inspection. Outside the home the surfaces underfoot no longer posed a risk for people. A new walkway with a handrail had been created and cracked pathing slabs replaced. Some internal decoration had been carried out in communal areas to make the home brighter and more homely.

Requires Improvement

Is the service effective?

Our findings

People were still not always receiving a service effective in meeting their individual needs.

At the inspection in September 2016 we identified staff were not suitably skilled and equipped to support and care for people safely and effectively. Improvements made since the inspection included training on MCA and DoLS, safeguarding and epilepsy including the administration of emergency medicines.

Talking with staff and members of the 'turnaround team' it was evident that further improvements around training were still required. This was particularly around fully understanding person centred approaches to care. This was recognised by many as was the need for greater understanding of providing support for those with behaviours that were challenging and improving verbal and non-verbal communication skills. This was because staff had limited skills in helping people when anxious, distressed or angry. They were not sufficiently skilled in communicating with people with limited vocabulary and did not always have the ability to think creatively in order to provide person centred care. Staff said the 'turnaround team' had helped them by providing role modelling and coaching in these areas but felt they needed further training. Most staff had received NAPPI training and had either completed or were working towards a vocational diploma in care (formerly known as an NVQ). We also saw some additional training had been arranged as the turnaround team had recognised this was necessary. This requires improvement to ensure staff have the skills and abilities to provide care and support for people with complex needs, including depression and anxiety, personality disorder and autism.

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

At the inspection in September 2016 we found the provider/registered manager and staff did not understand the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

Although staff had received training following the inspection of September 2016, we found staff still did not always have a clear understanding of the principles of the MCA or best interest decision making. Some people were anxious regarding their future. This was because their needs were being assessed to determine if the service could meet those needs. As a result of this, they were facing decisions about their future care arrangements and alternative places to live. Talking with staff it was clear they had difficulty in providing impartial assistance for people to make informed decisions. The provider had contacted one person's family to share their concerns regarding them moving. This had been done without careful consideration of the possible impact on the person, or how this may have influenced the person and family. There had been no

planning to ensure good communication was in place and the person was helped to make their own decision. We spoke with senior staff about this as the person was very distressed and confused. Although we explained to staff their role in supporting the person sensitively and without bias, we were not confident this was fully understood.

Another person was going through a best interest decision making process as they were unable to make the decision regarding their future without assistance. A social care professional involved in this process reported staff had 'not been helpful'. They had been meeting with the person to discuss their choices, when a staff member interrupted the meeting and stated they had not been consulted about the meeting.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for Consent.

At our inspection in September 2016 we found one person's DoLS authorisation had lapsed and, that a number of DoLS applications that had been submitted for other people were not authorised and returned by the authority(s) because those people had the capacity to make the decision themselves. The 'turnaround team' had taken responsibility for managing DoLS applications and we saw this had improved.

At the inspection in September 2016 the service used a CCTV system which enabled the office based staff to monitor people's whereabouts both within the home and the grounds There had not been any recent consultation/review with people, or anybody acting on their behalf, to seek their views on this level of surveillance. The provider/registered manager or staff could not see the need to review whether the system was beneficial and proportionate in balancing the safety benefits with people's right to privacy. After the inspection took place the CCTV was switched off and we received confirmation this had happened during our visits for this most recent inspection.

We saw there had been some improvements in some skills and abilities of staff. This was particularly noticeable regarding people being supported to make day-to-day choices. People told us they were able to make more choices and decisions. They said; "I make my decisions and I get help for the important decisions. But the simple decisions I make on my own. Now we can make tea and coffee as and when we like; we couldn't do that before" and, "There is a lot more choice, about food and activities, there's more to do". Staff told us they now felt they could consolidate and implement their learning from the additional training they had received. However, some expressed anxiety that positive changes in their practice would be reversed when the 'turnaround team' were no longer in charge and the provider took control and this was a concern.

At the inspection in September 2016 people did not have access to hot drinks or snacks when they wanted them. They were not empowered to make choices about what they ate each day and kitchen doors were routinely kept locked. Since the inspection people told us they had more choice over what they had to eat and drink. They said, "The food here is good and has got better since you were here last time. It is a better choice and if I get hungry at night I eat fruit", "We do our own shopping for groceries and now we can pick out our own meals. We can set it out on a menu every fortnight. This is a change since you last came here. We get a choice at lunchtimes now it was never like that before" and, "The food is good. I have bacon and eggs on Saturday and I like meat pie and chips". One staff member said, "Since you have been here the choice of food has really changed. We now sit down with the 'residents' and see what they want; they have a choice of menu".

At the inspection in September 2016 involvement from relevant health and social care professionals had not always been sought. Health and social care professionals told us they felt the service did not seek their

assistance and staff were sometimes resistant to support and guidance. Some improvements had been made and people were benefitting from more involvement with relevant professionals. As a result people's needs were better met and supported. Feedback from professionals continues to be mixed. Some reported staff had not always been helpful in ensuring people were available for appointments they had made. Others had noted improvements in the service provided, with some positive feedback given to work done by the 'turnaround team'. However many expressed concern the improvements made would not be sustained when the 'turn around team' were no longer in charge and provider took control. The manager put in place as part of the 'turn around' team explained that most of the positive changes were the result of work done by the home's own staff so he felt that the changes were sustainable.

At the inspection in September 2016 we could not be satisfied that staff supervision and support was effective because of the concerns we had identified during our visits. Staff felt this had improved in recent months, they felt better supported on a daily basis and their individual supervision sessions were more effective. Supervision is a one-to-one meeting a staff member has with their immediate supervisor, to discuss their performance, share concerns and measure their progress. Supervision records were brief but did contain details of conversations with staff on how they could improve their performance in providing care and support.

Requires Improvement

Is the service caring?

Our findings

People did not always receive a service that was consistently caring.

Staff we spoke with felt improvements had been made in providing a caring service. They acknowledged a person centred approach and ethos had been promoted and led by the 'turnaround team' and that additional training and support would help make further improvements. Many expressed concern that these changes would not be fully supported when the 'turnaround team' were no longer in charge and the provider took control. Staff reported that in the absence of the registered manager/provider, and with the support of the 'turnaround team', they felt more valued, empowered and 'liberated'. This had a positive impact on their well-being and as a result the care and support they provided to people.

At the inspection in September 2016 we found the service was not always caring. People confirmed this had improved. Comments included, "I think the staff here are very helpful. They encourage me to do things. They are my friends", "Yes I think the staff are caring, they are helpful with my laundry and at keeping me well," "Yes I am happy here" and, "It is better since the Inspectors came". People told us they were happier that their home was no longer being used as a day care service for everyone who used the providers other services.

The service as a whole however was not built around people's individual needs with care planning, the routines within the service and staff approach to people, all contributing towards dependence rather than independence being fostered. One person who lived at one of the services explained to us that the service provided was not suitable for everyone. They said, "Some people need more freedom but for me it works, I'm ok". Three people told us they were looking forward to moving to a service where they could experience greater independence.

We saw staff talking to people in a caring manner. The expert by experience commented that staff seemed 'more relaxed with the residents' than when they last visited. People gave mixed feedback on whether they were treated with dignity and respect. Comments included; "Yes they have always respected my privacy and my dignity, more so now that they have taken names off of the doors", "In the morning, they just come into my room; they knock and just come straight into my room which I don't like, they don't wait for me to respond" and, "They're not too bad. They can be a bit off with you. I get on with them and they usually get on with me".

During our previous inspection in September 2016 we identified the language and terminology used in people's care plans did not demonstrate dignity and respect. At this inspection we saw the negative comments we referred to had been removed. The Mr. Men characters displayed on people's doors that we reported at our inspection in September 2016 as being childlike and potentially insulting, had also been removed. We saw also that people's privacy had been better protected by additional screening being placed on the toilet door so they could not be seen.

Staff had received training on equality and diversity through their diploma in care and NAPPI training.

However, staff we spoke with did not have an understanding of their role in ensuring people's equality and diversity needs were met. Care plans did not assess people's needs with regards to equality and diversity. There was no appreciation of people's cultural or religious backgrounds, sexual orientation or any other relevant protected characteristic as defined in the Equality Act 2010. This requires improvement to ensure staff value people and afford them with dignity and respect.

When we inspected the service in September 2016 we found the service was controlled by routine. Staff locked doors routinely with no rationale for doing so. People then had to request access to rooms within their own home. House plans dictated when people did things. These included when they went to bed, got up and ate and drank. At this inspection we found improvements had been made and people now had greater control over their day-to-day routines. Comments from people included, "Sometimes we stay up until around ten or twelve but most of the residents go to sleep at around ten or eleven", "I have a shower, now, every day. We can have a lay-in in the mornings and we couldn't do that before you came here. Before they made us get up between 8am and 9am", "If I want to lie in in the mornings, I can, whereas I couldn't before. It is more relaxed now. I still like to go to bed between 9.30pm and 10pm but sometimes if they have a movie and popcorn night so I stay up later".

Doors to toilets, bathrooms and kitchens were no longer routinely locked. Bedroom doors were no longer locked by staff once people had got up for the day. People said they had greater freedom within their home. Comments included, "I have a key to my room so that I can lock and unlock it myself", "There are no restrictions, the doors are not locked and we can go shopping" and "I have seen all the changes here. They have taken locks off the doors, but I have always had a key to my own room for the last 15 years". Staff confirmed locks had been removed from doors following our last inspection. One staff member said, "None of the 'residents' doors have locks on, but three do have keys for their own rooms. The wardrobes are not locked anymore and they can now choose what they want to wear".

Inadequate

Is the service responsive?

Our findings

People did not receive a service that was responsive to their individual needs.

Although we noted improvements in the service provided to people, it was still not responsive to their individual needs. People still gave the impression of feeling they were required to fit into the service rather than the service being designed and delivered around their needs. In addition the service had failed to continually assess and support people in ensuring the service was still a suitable place for people to live. It was evident at the inspection in September 2016 that people's needs had changed and the service was not able to support them safely and effectively. They had also not encouraged people to develop and learn new skills so that they could live in a more independent setting. The provider/registered manager had failed in their responsibility to engage with commissioners who funded people's placements to ensure that placements were still appropriate. These opportunities had been missed. There was little forward planning to help people identify how their needs, wishes and aspirations could be best met.

As a result of the inspection in September 2016 health and social care professionals had a responsibility to re-assess placements due to the concerns we raised. Two people had moved from the service and others were working with professionals on exploring the option of moving. Staff had not communicated effectively with professionals to ensure these two transitions were as smooth as possible. Professionals gave examples of turning up for pre-arranged meetings to discuss future living options and, finding the person or relevant staff were not available to meet with them. They also reported staff had not always ensured people arrived at their new home with all their clothing, possessions and care records. The impact on people due to the lack of support and planning to ensure smooth transitions was unsatisfactory. For people who had moved the experience had been disorganised and potentially traumatic. We were told by a social care professional that one person who had recently moved now referred to Bedrock Lodge as 'the prison'.

Those considering moves were anxious both for themselves and others. One person told us they were so worried they had considered harming themselves. Staff did not seem to know how to respond to this. They had not communicated the person's concerns clearly to other health and social care professionals and, had not always shared their concerns in an appropriate manner with their family members. It was evident this anxiety, for this person and others, would have been alleviated by more sensitive and thoughtful, person centred planning.

The attitude of staff to other professionals was not always positive. Rather than seeing the professionals' support as helpful and in people's best interests. One member of staff referred to Bedrock Lodge as 'having been invaded'. This comment had been made at a previous multi-disciplinary meeting. On occasions the advice of visiting professionals had had not been followed. For example, on 17 October a visiting professional had requested staff to make a referral for physiotherapy and occupational therapy for one person. Following this person's move to their new home it was discovered this referral had not been made. The registered manager/provider had previously given us the impression of seeing an 'us and them' position with other professionals. This had meant people had received little involvement from other professionals. Although the 'turnaround team' had tried to change this attitude, it was still evident with some staff.

At the inspection in September 2016 care records lacked sufficient, detailed information and were not always written in a person centred manner. Staff had made attempts to improve care plans and these had been rewritten since our last inspection. They no longer contained value-laden judgements about people's abilities, behaviours and physical and mental health conditions. When asked people said they had not been involved in agreeing their care plans. Senior staff told us they had been involved in developing them. Some care plans contained statements that people had been involved in writing them others did not. It was also unclear as to what the service was trying to achieve with people. For example, people who wanted to move towards more independent living had few plans in place to assist them to do this. Care plans still contained lots of information about what people could not do, with little identified to help them learn, develop and grow. A consequence of this meant that some people who had used the service for a long time had become deskilled. They did not give a clear picture of people's life history, likes and dislikes or hobbies and interests. Where people required support to assist them to manage their behaviour some plans were in place. However, suitable measures were not always available for staff to support people in a sensitive, caring manner when people exhibited these behaviours. This meant the root cause of people's behaviour was not addressed but was often exacerbated.

These were continued breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

At the inspection in September 2016 there was little or no choice about the type of activity most people did during the day. They either attended 'day care' at Bedrock Lodge or planned community activity en-masse. Improvements had been made and activities were now being planned with people. The acting manager told us activities were now based on people's hobbies and interests. One member of staff made a comment that this would not have happened if it wasn't for the inspection that took place in September 2016. However we do have concerns that staff will be prevented from continuing with this when the provider/registered manager returns. We were informed during our inspection, of an incident where the provider had requested an activity was cancelled due to cost. This activity had been previously requested and enjoyed on several recent occasions by people. The trip involved a car journey to a local service station to enjoy a hot chocolate drink. The turnaround team and staff acknowledged this compromised their attempts to provide person centred activities chosen by people and, reinforced our previous concerns around control exercised by the provider/registered manager.

We spoke with a staff member who had recently been appointed as activities organiser. Although this initiative and role was in its infancy they had spent much of their own personal time exploring how to develop the role in order to ensure a person centred approach to activity that was meaningful to individuals. They were very enthusiastic and had a number of ideas they wished to explore with people and it was encouraging to meet with them.

We recommend that the service seek advice and guidance from a reputable source, about providing meaningful activities and stimulation for people so they are suitable equipped for their role.

At the inspection in September 2016 we found that complaints were not managed effectively. A system for managing complaints was now in place. Meetings were held for people to express their views. These had been led by the 'turnaround team' and easy read minutes were produced. Care had been taken to find out how people felt and discuss changes made and planned.

Since the inspection in September 2016 staff had met with people and families to explain the findings of our report and its potential implications. Feedback on these meetings had been mixed. Some people had found them helpful; others said it had caused them to worry more. Some relatives had attended meetings; others

had not received invitations in time to come. This must be improved to ensure staff keep people and relatives fully informed on changes that affect them.

Inadequate

Is the service well-led?

Our findings

The service was still not well led.

Since the inspection in September 2016 the vision and values of the service remained unclear. Although the provider/registered manager had appointed the 'turnaround team' following the inspection in 2016 we were unable to see how the improvements made would be sustained if the 'turnaround' team were to leave. We wrote to the provider/registered manager following our inspection under Section 64 of the Health and Social Care Act 2008. We asked when the 'turnaround team' would be withdrawing, the plans to manage this and the strategy for managing the service once they had left. The answers we were given were vague and they told us a date for withdrawal had not been identified and that plans were yet to be agreed.

At our inspection in September 2016 we found the provider/registered manager did not always have people's best interests at the heart of their service. They had been resistant when offered support, guidance and advice from community, health and social care professionals. There was a lack of insight and vision as to how they intended to improve the service. Systems for monitoring the quality of care were not robust enough and had failed to identify the serious failings of the service. The provider/registered manager and staff lacked understanding and passion in, providing high quality person centred care.

Throughout our inspection staff told us they were concerned any improvements would be reversed when the 'turnaround team' were no longer in charge and the provider took control. Some senior staff told us they felt they were able to withstand attempts to do this; others felt it unlikely they wouldn't be able to do so. Staff shared with us concerns that the registered manager/provider was monitoring what they were doing through the CCTV system. We were assured by the 'turnaround team' this wasn't the case. However, it was clear to us a number of staff had little trust in the registered manager/provider.

A number of the provider's policies and procedures needed reviewing, many were dated 2013 and contained out of date information. This meant staff were not able to benefit from up to date advice and guidance.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At the inspection in September 2016 we found that people had not been kept safe from the risks posed by inappropriate staff behaviour. The registered manager/provider had not investigated concerns shared with them. For example concerns regarding two particular staff members behaviour towards people had been brought to their attention in September and October 2016. The registered manager/provider had not investigated these or taken any action by their leave of absence in January 2017 to ensure people were kept safe. We spoke with a member of the 'turnaround team' and they gave us assurances of the action they had subsequently taken to keep people safe and investigate the concerns. This was ongoing at the time of this inspection.

Systems were not in place to ensure people were safe from the risk of financial abuse. At our last inspection

we noted, the provider/registered manager had failed to follow best practice by ensuring arrangements to manage people's finances were transparent and had not arranged for any independent audit of these records. We recommended the provider/registered manager reviewed the systems for supporting people to access and manage their finances. Since then a full financial audit had been completed by the local authority. This had resulted in a number of actions for the provider/registered manager. This included a full reconciliation of monies charged to people for holidays and activities against the actual costs incurred. This work is ongoing. Two people who moved to new homes had to wait for some considerable time before their money was made available to them. The provider/registered manager also needed to be prompted by the local authority to take the appropriate action to ensure money held on behalf of a person who had died was passed to the appropriate body.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The provider/registered manager and senior staff had not always submitted notification forms to CQC as required by law. These notifications informed CQC of events happening in the service. Since our inspection in September 2016 there had been one occasion where a notification had not been submitted. This was in relation to one person who had acquired a significant injury which should have been brought to our attention under our regulations.

This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

When we inspected in September 2016 we found the experience of people using the service was of a closed environment. They lived at the service, used the day care facilities at the service and activities and holidays took place mainly in groups. This raised the risk of people becoming further isolated from their family and friends and the wider community. This had not been recognised as a risk factor. The overall impression of the service at that time was that it was deskilling people rather than promoting their independence, value and self-worth. At this inspection we saw some improvements had been following the input from the 'turnaround team'. People were now able to experience greater community involvement and more input from other health and social care professionals. Staff we spoke with recognised the benefits of this but were not confident this would continue when the 'turnaround team' were no longer in charge and the provider took control.

We looked at the minutes of a staff meeting held in November 2016. The notes of this meeting reflected a controlling approach of the registered manager/provider and merely provided staff with a list of instructions. Staff were not encouraged nor did they feel empowered to contribute to the meetings in a positive way. For example staff told us they were not encouraged to share views, experiences and concerns, consider best practice and look at ways to improve the service. The notes of the meeting held in January 2017 chaired by the 'turnaround team' showed a more participatory style, with staff views and involvement sought in problem solving. Staff enjoyed these meetings and found them more helpful. Staff were not confident this would continue when the 'turnaround team' were no longer in charge and the provider took control.

At our last inspection in September 2016 we found the provider was not displaying the most recent review of their performance on their website. We found at this inspection the provider had ensured their website included a link to our most recent inspection of the service.

On 16 February 2017 we gave feedback on our findings up to that point. The feedback session was attended

by the project manager, two members of the 'turnaround team', the acting manager and the assistant managers from each of the provider's three locations. Our overall feedback noted the positive improvements in the service provided, whilst highlighting our concerns regarding the sustainability of these. We also discussed new areas that were of concern.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications as required by law. (18) (2).

The enforcement action we took:

Notice of Proposal to cancel provider's registration issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured service users were enabled and supported to understand the care and support options available to them and, discuss them with competent health and social care professionals balancing the risks and benefits without influence. (9) (3) (c). The provider had not worked effectively with other health and social care professionals to effectively assess service users' needs. (9) (3) (a). The provider had not ensured service users care and support was designed to meet their needs, wishes and aspirations. (9) (3) (b).

The enforcement action we took:

Notice of Proposal to cancel the provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care and support was provided in accordance with the Mental Capacity Act 2005. (11) (1).

The enforcement action we took:

Notice of Proposal to cancel the provider's registration has been issued.

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 not ensured risks to the health and safety of service users had been assessed. (12) (2) (a). The provider had not ensured staff were sufficiently knowledgeable of risk assessments. (12) (2) (b). The provider had not assessed the risks and put measures in place to control the spread of infection. (12) (2) (h).

The enforcement action we took:

Notice of Proposal to cancel the provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not carried out investigations to keep people safe from being subjected to being treated in a degrading manner. (13) (4) (b). The provider had not protected people from the risk of financial abuse. (13) (3).

The enforcement action we took:

Notice of Proposal to cancel the provider's registration has been issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and improved the quality and safety of the service because, they had not worked to ensure improvements would be sustained. (17) (2) (a). The provider had not ensured policies and procedures were kept up to date. (17) (2) (d).

The enforcement action we took:

Notice of Proposal to cancel the provider's registration has been issued.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had received the training required to meet the care and support needs of service users. (18) (2) (a).

The enforcement action we took:

Notice of Proposal to cancel the provider's registration has been issued.