Buckinghamshire Care Limited

Seeleys Respite Centre

Inspection report

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23 November 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Seeleys Respite Centre provides short term accommodation to adults with profound learning disability, some of whom will have a physical disability. The service is registered to provide support to 12 people. At the time of out inspection seven people were being supported.

This comprehensive inspection took place on 14 and 23 November 2016. It was conducted to follow up on previous enforcement action taken.

We previously inspected the service on 12 and 13 April 2016. We found breaches of the Health and Social Care Act 2008. We found people who used the service were not protected against the risk of unsafe premises and environmental hazards. We took enforcement action to ensure people's safety and ensure improvement occurred at the service. We served a warning notice to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be compliant by was 30 May 2016. The provider sent us an action plan detailing how they intended to improve. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Seeleys Respite Centre' on our website at www.cqc.org.uk.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At this inspection we found the service had not responded to our previous concerns. We found continued breaches of the Health and Social Care Act 2008. People were still placed at risk due to unsafe premises. The service had not assessed hazards within the home for instance, we found a number of items were easily accessible to people which could have posed as a strangulation risk. We found a light fitting in the main dining area had exposed electrical wires which could have caused harm to people.

Risk posed by the environment had not been assessed and reduced. In all twelve bedrooms we found loose electrical cables. These were from televisions, radios and sensory equipment. The cables presented a risk to people as they could be used for self-harm, or could have caused an accident. Staff were not clear on the support people required in the event of a fire. Risk to people had not been assessed and reviewed to ensure support was available to reduce the likelihood of harm.

The environment had not been kept clean and was not well maintained. We found open waste bins in communal areas. This meant people had access to waste.

People were not protected from abuse. Some people had come to harm as a result of physical assault by other people who used the service. We found incidents of physical abuse had not been reported to the local authority or to CQC. We found the service had not investigated these incidents to prevent people being

harmed in the future.

People were not supported to exercise their human rights. The service failed to act within the core principles of the Mental Capacity Act 2005. Where people had been assessed an incapable of consenting to care and treatment, the service did not ensure it followed a best interest process to ensure the person's rights were upheld.

People were not always treated with dignity and respect. We found curtains did not sufficiently cover windows. This meant people could be viewed from the outside. We observed people who were not receiving support from the service had free access to the home. We observed one person walking into office areas, bedrooms and communal lounges. This person had not been invited into the home by anyone staying at the service.

The service did not ensure people received their medicines as prescribed. We found that some people did not have an up to date consent letter from their GP, verifying the medicines they were currently prescribed. Therefore, we could not be assured that the service was administering the correct medicines to people. We have made a recommendation about the pre-admission process in the report.

The service did not have robust recruitment process, which meant it did not ensure staff employed had the right skills and attributes to work with people. We received concerns from staff about staffing levels. Some staff felt they were placed at risk of harm due to staffing numbers being too low. We spoke with the registered manager about this. They felt staffing was adequate. Staff were shared with the adjoining day centre. We have made a recommendation about staffing in the report.

We found people were not actively involved in decisions about their care. We found staff did not have the skills to expand their communication style to suit a person's individual need. The service did have an 'inclusion' notice board. This included information about other services the provider offered. We found easy read versions of information were not made available to people. We have made a recommendation about this in the report

The service was not well led. The service failed to notify CQC of certain events when it was legally required to do so. There is a requirement for services to be open and transparent when things go wrong. We call this duty of candour (DOC). There are clear responsibilities on registered services. We checked if the requirements of this had been met. We found at least six incidents which met the DOC threshold. We did not find any records confirming that the required actions had been undertaken. We spoke with the registered manager about this and they could not provide us with reassurance this regulation had been met.

Due to the level of concerns about the service we received throughout our inspection and the lack of action following our previous inspection. We had considered urgent action under our powers in Section 30 of the Health and Social Care Act 2008. We asked the provider to detail how they intended to ensure people's safety. Due to the prompt response from the provider and the local authority to our findings to reduce the immediate risk to people we decided not to pursue this course of action.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a breach of the Care Quality Commission (Registration) Regulation 2009. You can see some of the action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from harm because the service did not identify and reduce risks associated with the environment.

People were placed at risk of physical harm and some people had been physically assaulted by other people who used the service.

The service did not ensure the environment was clean and fit for purpose

Is the service effective?

Requires Improvement

The service was not always effective.

People did not have their human rights protected, as the service did not work in accordance with the Mental Capacity Act 2005.

People were assisted by staff who were not supported in their role and in line with the provider's own policy.

People were not always consulted about how they would like to be supported.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People did not have access to information in a format that they could understand.

People who did not use speech to communicate received less attention that those who could easily engage with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had limited access to activities.

The service did not ensure it was prepared and had up to date information about people prior to when they arrived at the service.

People could not be confident complaints would be dealt with in a timely manner.

Is the service well-led?

Inadequate

The service was not well-led.

People were not supported by a service that responded and acted upon concerns.

People could be not certain any serious occurrences or incidents were reported to the Care Quality Commission. The service had failed to report incidents when it was required to do so.

The service did not use quality assurances process to drive improvement.

Seeleys Respite Centre

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.

The inspection took place on the 14 and 23 November 2016 and was unannounced; this meant that the staff and provider did not know we were visiting. The first day of the inspection was carried out by an inspector and an inspection manager. On the second day the same inspector was joined by another inspector.

We did not ask the provider to complete a Provider Information Return (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the two people living at Seeleys Respite Centre who were receiving care and support; the registered manager, the safeguarding and quality co-ordinator and the interim managing director. We spoke with five care staff. We reviewed seven recruitment files and nine people's care plans, including records relating to their medicine. We looked at records relating to health and safety within the service and cross referenced practice against the provider's own policies and procedures.

Following the inspection we received information from two relatives and we contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and health or social care professionals responsible for people who lived in Seeleys Respite Centre.

Inadequate

Is the service safe?

Our findings

At the previous inspection carried out on 12 and 13 April 2016 we found people who received care and treatment were not protected from avoidable harm. We found multiple breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a number of risks to people which had not been identified and assessed. We found people were at risk as cords on window blinds were not secured, which presented as a strangulation risk. In two toilet areas we found clinical waste bags and cable ties, this also presented a risk of choking if people ingested them. In a bathroom and toilet area we found portable aerosol air freshener, which could have been inhaled by a person.

We took enforcement action to ensure people's safety and ensure improvement occurred at the service. We served a warning notice to the provider following the inspection. A warning notice gives a date the service must be compliant by. The date the service needed to be complaint was 30 May 2016. The provider sent us an action plan detailing how they intended to improve. At this inspection we looked for evidence the service had made the required improvements to satisfy the warning notice and prevent future harm to people.

On the first day of the inspection we found portable air freshener canisters in the one toilet area. These could have been inhaled by service users. We found a window blind in a bathroom had a cord which was not secured, which presented as a strangulation hazard. In the same bathroom we found two bottles of toiletries which could have been ingested by people. We found rolls of clinical waste bags in the two toilet areas and cable ties in one toilet area. We bought this to the attention of the registered manager. They removed the items from the area. We advised the registered manager these issues had been highlighted in the warning notice and presented a risk to people. On the second day of the inspection we found two rolls of clinical waste bags in one toilet area. These could have been used by service users for self-harm and presented a choking or suffocation risk. This meant the service had not reduced the risk of harm to people and had not taken on board CQC concerns.

At the previous inspection on 12 and 13 April 2016. Staff did not know how to support people in the event of a fire as no personal emergency evacuation plans (PEEP's) could be found and staff did not have knowledge of them. A fire inspection risk assessment carried out on 15 July 2015 made a recommendation that (PEEP's) should be readily available in a 'grab bag'. This was reinforced by a fire risk assessment date 14 July 2016 carried out by an external consultancy company. Their report stated "An emergency grab bag should be available with the necessary equipment and information as per HMG guidance". We checked if this information was in the grab bag. It was not, we asked a member of staff where they would go to find information about how to support a person in the event of a fire. They told us a PEEP should be in the grab bag. We asked them to look; they could not find this information in the grab bag. This meant staff could not readily access information to support people to remain safe in the event of a fire and the service had failed to act on previous concerns raised by CQC.

On the first day of the inspection we noted disposable gloves were accessible to people in communal bathroom and toilet areas. We found portable trolleys in each bedroom, which contained disposable gloves, an aerosol of body wash and cleaning cloths. We spoke with the registered manager about this as gloves

were a known choking risk if ingested by people. They advised us they had removed the trolleys into another area. On the second day of the inspection we observed trolleys were present in bedrooms and all the gloves had been left in the communal bathroom areas. This meant the service had not responded to our concerns on the first day of inspection.

We found a number of areas within the home which required immediate action to ensure people's safety. However these were not responded to quickly by the provider. On the first day of the inspection we found a light fitting in the main dining room was unsafe. The light fitting did not have a shade on it. This led to exposed electrical wires. We reported this to the registered manager who advised us they would report it for repair. On our second day at the home, the light was still in the same state. This meant people had not been protected and the registered manager and provider had failed to act in a timely manner. We expressed our concerns about this and after the inspection we received reassurance the light had been made safe.

In all twelve bedrooms we found loose electrical cables. These were from televisions, radios and sensory equipment. The cables presented a risk to people as they could be used for self-harm, or could have caused an accident. We spoke with the registered manager about this on day one of our inspection. On the second day of our inspection we found remedial action had not been taken. This meant people were not protected from unsafe premises.

Risks posed to people from unsafe water temperatures and water quality were not adequately assessed and reduced. On the second day of the inspection we found water temperatures in sinks and baths were being recorded as high as 60 degrees Celsius. This exceeded 44 degrees Celsius which is the safe upper temperature recommended by the Health and Safety Executive. There was no guidance for staff on what was the safe temperature and no action had been taken to manage the risks associated with this. We found measures were not in place to guard against the risk of Legionella. There was confusion amongst staff as to whose responsibility it was to undertake the required regular checks. We found gaps in the required checks. For instance less frequently used water outlets required weekly flushing to ensure the risk of Legionella was reduced. We checked the records and found the last flush conducted on one outlet was 26 September 2016. This meant people were at risk from unsafe premises as the required checks were not routinely carried out.

Risks posed to people as a result of their medical condition or level of disability were not always assessed and reviewed to ensure people received safe and appropriate care. For instance one person had received medical attention following choking on a piece of food. A risk assessment was in place dated 12 March 2014 for eating and drinking. The risk assessment stated "Food to be cut into small pieces and well moistened. Encourage to swallow and drink plenty". This supported an assessment carried out by a speech and language therapist (SALT). We checked if the risk assessment had been updated since the episode. We found no evidence of this or an onward referral to SALT for a review. We found no incident form for the event. We spoke with the registered manager and senior care worker about this. Both parties told us the incident form had been completed. Neither could not find the completed incident form when they looked for it. The registered manager was unable to tell us what action had been taken to prevent a future similar event.

Another person who used the service had a deep pressure sore, which required to be nursed by district nurses. Their risk assessment was last reviewed on 20 October 2015. The risk assessment did not make reference to the pressure sore and what observations staff needed make. The person had arrived to stay at the service on the second day of our inspection. No provisions had been made to ensure they received appropriate care and treatment for the pressure area during their stay at the service.

We received information from staff regarding a number of aggressive incidents which had occurred within the service. One incident involved a person who liked to use DIY tools. We looked at the records relating to

their first stay in the service. We noted the dates they had stayed and the dates on a risk assessment completed by the registered manager. The risk assessment was written five days after their first night in the service. We spoke with a senior support worker; they confirmed the risk assessment was not in place on the first night the person stayed in the service. This meant staff did not have the knowledge to reduce risks posed to them and other people who used the service.

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

People were not always protected from unsafe practices around medicine management. At the previous inspection we made a recommendation about ensuring only people who had been assessed as being able to administer medicine should have access to medicine keys. On day two of this inspection we found the medicine trolley in the main lobby area. The door was open and the keys were hanging on the side of the trolley. Inside we found an unlocked cash tin with keys to all medicines, including those which required additional safe storage. This meant that any unauthorised personnel had access to medicines. This meant the service had not taken on board previous concerns raised by CQC.

The service requested information from a GP about a person's prescribed medicine. We found that some people did not have an up to date consent letter from their GP, verifying what medicines they were currently on. Therefore, we could not be assured that the service was administering the correct medicines to people. We also saw that people had an emergency grab sheet, to take with them if they were admitted to hospital. On several of these forms, the medicines were different from the current medicines prescribed. On day one of our inspection a person had been admitted to the service with a hand written note from their parent about changes to the person's medicine. The service was unsure if this change had been authorised by the GP. This information could have been sought prior to the person being admitted to the service.

At the previous inspection we made a recommendation about 'as required' medicine (PRN). We found practices had slightly improved regarding this, however we found one person was prescribed PRN medicine. The information available to staff on when and how much of this medicine should be administered was conflicting. One document stated 'only one to be given in 24 hours' the other document stated a 'maximum of two tablets in 24 hours'. This meant the service had not taken on board previous concerns raised by CQC and had not implemented a robust system to ensure people received their medicines safely.

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

People were not always protected from abuse. Some people had been victims of physical assaults from other people who used the service. We found three incidents which happened in the service since the last inspection. They involved people being harmed by another person who used the service. None of the incidents had been reported to the safeguarding local authority or to CQC. This meant the incidents had not been externally investigated. We checked the records within the service and found internal investigations had not been carried out. This meant no learning or prevention was put in place to prevent any future incidents. The registered manager told us they were not aware of the incidents.

Staff we spoke with had an understanding of what abuse was and how they would report it, however processes were not clear in the service as to who should do what when a safeguarding concern was raised. Staff told us they did not have confidence in the management team to deal with concerns raised. We did not have confidence in the service that appropriate systems were in place to learn from previous events and prevent future safeguarding concerns.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Incidents and accidents were not always reported in line with the provider's own policy and procedures. There were no clear processes for accidents to be reported to the registered manager. This meant important events that required reporting to external agencies including CQC did not happen. It also meant investigation did not take place to identify how repeated incidents could be prevented.

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

We found people were not protected from potential risks associated with poor infection control. We observed a number of the areas of the home were in a poor state of cleanliness and poorly maintained. All the toilets in the building were stained as well as many sinks throughout the service. There was visible dust and dirt in many areas of the home. In some of the bathrooms the sealed flooring had come away from the wall. This presented areas which were unable to be cleaned effectively which could harbour bacteria and cause infections. We noted in two of the bathrooms clinical waste bins did not have lids. This meat the contents were easily accessible to people and any odours were not controlled. The service did have support from domestic staff, however we found no advice or guidance for them on what should be cleaned and how regularly.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the previous inspection we made a recommendation about the recruitment processes, as we found some staff had been allowed to commence employment prior to an enhanced Disclosure and Barring Service checks (DBS). A DBS is a criminal records check. The service's policy stated a full risk assessment should be conducted. In the records checked at the last inspection we found this was not always the case. At this inspection we found improvements had not been made to recruitment practices. In all the recruitment files checked we found failures to assess a member of staff's suitability for the role. This meant there was not a robust system in place to ensure staff with the right silks and attributes were employed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not always supported by a safe number of staff. The registered manager told us they felt the service was adequately staffed. However staff told us they felt the staffing was insufficient to meet people's needs. We were provided with examples from staff when they felt staffing numbers were lower than the staff felt safe with. On one occasion a person who was funded for one to one support was left with no one to one support overnight. We spoke with the registered manager about this. They advised us the staff were shared with the adjoining day centre. This made it difficult for us to comment on safe staff numbers. On day one of the inspection we noted staff working on the afternoon shift also had the responsibility to prepare and cook a meal. The staff on duty told us they found this difficult as it took one member of staff away from caring for people during this time.

We recommend the service ensures safe staffing levels are assessed and monitored.

Requires Improvement

Is the service effective?

Our findings

People did not receive care and treatment that protected their human rights. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the previous inspection we found breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The service was unable to provide evidence of how people had consented to care and treatment. We found a number of family members had signed consent forms for their relative. The service had not ensured the family members had legal authority to act on their relatives' behalf. We asked the provider to send us an action plan detailing what improvements they would make to ensure it complied with the MCA. They told us improvements would be implemented by 20 June 2016. We checked what actions had been undertaken and whether the service was working within the principles of the MCA and if any conditions on authorisations to deprive a person of their liberty were being met.

We found the service had started to assess and record if people had mental capacity to consent to care and treatment. We observed initial assessments were dated 3 August 2016. These assessments were relating to "all aspects of care, consent to treatment, medication, activities, holidays, environment, finances, staff and any day decisions." This was not in line with the MCA as a decision needs to refer to a specific question. We found later mental capacity assessment completed on 5 September 2016 were specific to individual decisions . However where people had been assessed as not having mental capacity to decide to accept care and treatment, no best interest discussion took place to ensure care was provided in the person's best interest. We spoke with the registered manager about this and they advised the service had only just started to use the MCA forms. This meant the service had failed to rectify the previous failings highlighted by CQC in the time scale they advised they would.

These were all continued breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were cared for by staff who were not supported in line with the provider's own policy and procedures. These detailed how staff should be supported and provided timescales for a probation period. However the management and senior staff responsible for the induction and supervision of staff did not follow the policy. This meant staff were not supported in their role. This was reinforced by what staff told us. One member of staff told us did not feel supported by the registered manager; they told us how "Things get brushed under the carpet and ignored."

Staff did receive some training to equip them with the skills to undertake their role. However, there was a lack of oversight of the training required by staff. We looked at training records and noted some staff had not received training since 2013 in safeguarding people from abuse for instance. The main record used by the service to monitor staff training did not have all staff members' details on it. We found there was no robust system in place to ensure staff received appropriate training to perform their duties.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed a person having their breakfast on day one of the inspection and observed a tea-time meal on the second day of the inspection. We spoke with the cook who worked three days a week in the respite unit. People had a file in the kitchen which detailed their likes and dislikes. It also included dietary requirements related to religious beliefs. Staff were aware of the need to provide a balanced diet. The meals we observed being served looked appetising. The cook told us how they had been updated on a person's requirements following a choking episode. However when we checked the records the advice they had been given was no different to the care plan. This meant the service had not assessed if any changes in diet were required to reduce the risk of choking.

People were supported to manage meals where required. However we found communication was poor when staff assisted people at mealtimes. For example, one member of staff did not speak to the person they were supporting. This meant the person had no idea what their meal was. Another member of staff did speak with the person they were supporting; however, the person had no verbal communication. The member of staff did not use any other forms of communication with them to ensure they understood what their meal was.

We found the service did receive some information from specialist healthcare professionals when needed. For instance one person had a report from a speech and language therapist, another person had a report from a psychiatrist which detailed their medicine regime. We found where people required daily or ad hoc medical attention whilst staying at the respite unit this was not well managed by the service. The service could have improved the pre-admission process to ensure people had access to healthcare when required.

We recommend the service reviews its pre-admission process to ensure people receive safe care and treatment.

Requires Improvement

Is the service caring?

Our findings

We observed some mixed practices regarding how staff treated people. One person told us "They (staff) are really good, I like the staff, and we have a laugh." This person had remained in the home for the morning of our second day of inspection. We observed them interact with staff. Staff appeared to understand the person and were knowledgeable about their likes and dislikes. However we observed some language used was not appropriate. Staff told the person "Good boy." We spoke with the safeguarding and quality co-ordinator about this. They informed us all staff had received professional boundary training. Later the same day whilst observing a meal time we again overheard a different member of staff staying to another person "good boy" and referred to them as being "naughty." This meant people were not always being treated in a respectful manner.

Although staff we spoke with were knowledgeable on how to promote people's dignity and gave us examples of how they would do this, we found people were not always treated with dignity and respect. On day one of the inspection we found curtains in two rooms did not cover the window adequately and left no protection for people. Both rooms had been occupied on the night before the inspection. All the curtains in the bedrooms were thin and did not provide adequate privacy from onlookers from outside. This meant people were not provided with adequate privacy. We spoke with the registered manager about this. They confirmed that staff were able to adjust the curtains. However on the second day of the inspection we still found curtains did not provide adequate protection.

We observed a person who was not supported by the service had free access to bedrooms and communal areas. People who used the service had not been consulted about the other person being in the building. This meant their privacy and dignity had not been maintained.

On day one of our inspection we found private information regarding a former resident was displayed in a bedroom. In another bedroom we found personal belongings relating to another person who was not present at the service.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found people were not actively involved in decisions about their care. We found staff did not have the skills to expand their communication style to suit a person's individual needs. The service did have an 'inclusion' notice board. This included information about other services the provider offered. We could not find easy read versions of information available to people.

We observed staff concentrated their engagement with people who were able to talk to staff. People who did not communicate through spoken language received less attention from staff. We spoke with the provider about this.

We recommend the service ensures people have access to information in a variety of formats they are able

to understand and are supported to express their views.

Some staff were able to tell us about the people they looked after and how they understood what people liked to do. We did observe some positive interactions between staff and people. One member of staff was talking to a family member on the telephone. They demonstrated kindness and compassion and provided some professional advice. It was clear the family member thanked them for their time.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive person centred care. We found mixed practise regarding the records relating to what care should be provided. Some care plans very clearly documented information about the person, their likes and dislikes. Where completed fully, a form titled 'one page profile' gave an outline of the person, including how they would like to be addressed and how they communicated with staff. It also included information on 'what people like about me'; This gave information to the reader about a person's personality and how they usually presented. This was particularly important for people who did not use speech to communicate.

We found some care plans had been updated. There was some evidence of reviews taking place. However the records did not consistency provide an up to date record of how a person required to be supported. Where undertaken reviews did not detail who had been involved in the review.

One person had not attended the service for a long period of time. Their condition had deteriorated due to health complications. We checked their risk assessment. The last time it was reviewed was 20 October 2015. It made no reference to the person's current needs. We also checked their care plan, this was last updated on 2 May 2014 and was not reflective of their current needs.

Care plans had varying degrees of detail completed. More fully completed care plans detailed a person's health, daily living skills, relationships and aspirations. The care plan was written in the first person and gave the reader a clear summary of what to do and what not to do. Care plans referred to people's medical conditions; however they did not provide staff with any guidance on what they should look out for to identify deterioration in the condition. This meant there was a risk of people not receiving the correct care.

We looked at a person's behavioural care plan. This had been written by the registered manager on 28 September 2016. It stated the details would be reviewed weekly by the registered manager. We could not find any reference to a review taking place. We asked the registered manager and they told us they had reviewed the content. However no records had been completed to demonstrate this.

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

The service had a complaints procedure; however the one available to people was not the updated version. This was rectified during our inspection. The service held a paper based copy of complaints and had an electronic system. We checked both records and they did not match. The service had received a complaint on 26 August 2015, we found no evidence this had been resolved or responded to. Another complaint was made on 6 April 2016 regarding the telephones. We found no evidence this had been resolved. We spoke with the registered manager about this. They told us it was resolved but there were no records confirming what action had been taken to resolve the complaint. The service was supported by a safeguarding and quality co-ordinator. They had identified the two systems did not match in an audit conducted in September 2016. The provider had been made aware of this at the time. We found improvements had not

been made since this was brought to the provider's attention.

These were breaches of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff told us some activities happen within the home, which people could choose to engage with or not. On both days of the inspection one person chose to stay in the home for the morning. We observed on both days the person was left to their own devises. No planned activity had been arranged for them. However on the second day the person had a pre-arranged activity away from the home. This was not arranged by the service. Staff talked to us about how the service had celebrated Halloween and how they intended to hold a Christmas fair in the near future.

On the second day of the inspection we noted it was a person's birthday, the staff had gone out of their way to buy a cake and were looking forward to supporting them celebrate.

Inadequate

Is the service well-led?

Our findings

People were supported by a service that was not well led. We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found there was a failure to act on previous concerns raised by the CQC.

There is a legal requirement for providers to inform CQC when specific events happen. We call these notifications. One event is when abuse or alleged abuse had occurred. At the last inspection we found a safeguarding referral had been made to the local authority, but it had not been reported to CQC. We asked the provider to send us an action plan detailing what improvements they would make to ensure it complied with the notifications requirement. They told us improvements would be implemented by 27 May 2016. We checked what actions had been undertaken and whether the service was informing CQC when it was required to do so. We found four incidents which should have been reported to CQC which had not been made. We spoke with the registered manager about this. They told us they had no knowledge of the events. This meant the registered manager had failed to implement an effective system to ensure CQC were informed of all reportable events.

These were all continued breaches of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a registered manager in post. This was their first registered manager's position. However they had been the service manager for the home for the last twelve months. The provider's senior managerial team had had a number of changes in personnel. This meant there was consistent oversight by the provider. This was reflected in comments from staff. Staff felt unsupported and left at risk. We received feedback from staff that they felt there was not enough staff on duty and people who had been aggressive had not had their needs assessed to ensure enough support was provided. This was echoed by feedback from relatives. Two relatives contacted us following the inspection to tell us how they were concerned about staffing levels and the balance of people's needs who used the service.

There was no clear vision or values demonstrated by the registered manager or staff. We found there was a blame culture within the organisation. Staff felt they could not talk to us on the inspection for fear of reprisal. The registered manager was critical of the provider's previous managerial style. We spoke with the provider about staffing levels and the feedback we had received. The provider's current senior management acknowledged some of our concerns and agreed that stable management was required moving forward.

There is a legal requirement for providers to be open and transparent. We call this duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation. We found at least six incidents which met the threshold for duty of candour. We could not find any records confirming that the required actions had been undertaken. We spoke with the registered manager about this and they could not provide us with reassurance this regulation had been met.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not supported by a service that had robust filing systems in place to ensure people were protected from harm and they received appropriate care and treatment. We found poor practices in records management. This related to records about to the environment, fire procedures, risk management and health and safety. When we asked for information the registered manager found it difficult to find it. For example we asked for information at 10.00 am on day two of the inspection. At 17.00 we had still not received the information requested.

The service was supported by a safeguarding and quality co-ordinator. We reviewed a number of the audits completed. We found these had picked up some of the issues we found on the inspection. We noted that feedback had been previously given to the provider about gaps in records and where improvements were required. However no actions had taken place as a result of the feedback. This in part was due to a change in personnel.

The audits conducted did not highlight all of the concerns we identified during the inspection. This was because they looked at information at a superficial level. For instance they commented if a care plan was present, rather than if the care plan was reflective of the person's needs. We provided feedback to the co-ordinator and provider about this.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service did not ensure all of the required notifications were made to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not ensure people's dignity and privacy was maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not ensure it acted within the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service was not fit for purpose, there was a lack of effective cleaning and many items of furniture required repair.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service failed to respond to complaints within their own policies timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service did not ensure all of the required pre-employment checks were completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not ensure when required to do so it met the Duty of Candour requirements to apologise to people when things go wrong.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not ensure staff were supported with regular one to one meetings.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service did not ensure people were protected from unsafe premises and did not ensure it had robust safe practices around medicine administration.

The enforcement action we took:

We issued a notice of proposal to add a condition to the providers registration.

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 service failed to report actual physical abuse to the local authority and to CQC.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of managerial oversight and accountability to respond to concerns and drive improvements.

The enforcement action we took:

We issued an notice of proposal to add a condition to the providers registration