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Tosh Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 April 2017, was unannounced and carried out in response to concerns raised with us by the local safeguarding authority.

Tosh Lodge is registered to provide personal care and accommodation for up to five people with mental health conditions. There were five people using the service during our inspection; who were living with a range of mental health needs. As well as needing support with their mental health, some people required more care and support related to their physical health.

Tosh Lodge is a large house situated in a residential area of Ashford. There was a communal lounge available with comfortable seating and a TV for people to watch. There was also a kitchen with a dining table and chairs and utility room. The service had a small, secluded garden at the rear. People's bedrooms were on the first floor, along with shared bathroom and toilet facilities.
This service is not required to have a registered manager in post. The provider had registered with the Care Quality Commission to manage the service and is therefore a 'registered person'. 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.

Tosh Lodge was last inspected in March 2016, when it was rated as good. At this inspection we found that risks to people had not been properly addressed or minimised in a number of areas. These included risks to people's health, safety and well-being from a lack of staff knowledge, environmental hazards such as fire and risks associated with medicines. Prior to the inspection we received information from the local safeguarding authority that some people living in the service had raised concerns with them about their experiences of the support provided.

Systems designed to protect people from abuse and harm had not been effectively operated. Recruitment processes were not sufficiently robust to make sure that only suitable staff were employed to work with people.

There were insufficient skilled or trained staff available to meet people's needs. Staff had received most mandatory training but had not been trained about mental health conditions, epilepsy or diabetes. Supervision by the provider had not picked up on shortfalls in staff knowledge.

Care plan information was not clear about how people gave their consent; taking into account some people's communication difficulties.

People's health was generally monitored and they had access to regular appointments with health care professionals. Support for one person had not been sought when their condition changed.

People gave us mixed feedback about food provided in the service. Menus had been improved recently but

still required greater input to improve variety and choice.

Staff interaction was not always very engaging but people said they felt supported by staff; who were polite and respectful during the inspection. People's independence was not consistently promoted and they were unnecessarily restricted in some areas.

Care planning was not person-centred and did not reflect people's individual personalities and preferences. People could join in with organised activities or pursue their own interests.

The provider said they had received no complaints However, the local safeguarding authority made us aware that before and after our inspection, some people living in the service had told them they were not completely happy with the way it was run and did not always feel able to speak out about their concerns.

There was inadequate oversight by the provider to identify and remedy the issues we found during this inspection. As a result we found a number of breaches of Regulation relating to people's health, safety and well-being. There was evidence to indicate that a restrictive culture was in place in some areas and that the provider was not always knowledgeable about their responsibilities as a registered person.

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.

Risks to people had been identified but not consistently minimised.

Medicines had not always been safely managed.

Systems designed to protect people from abuse or harm had not been operated effectively.

Recruitment practices were not sufficiently robust.

There were enough staff to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Staff training was lacking in some areas; which meant they were not fully equipped to carry out their roles effectively.

People had access to health care but actions had not always been taken to ensure the most appropriate professional input was sought for people.

People gave mixed feedback about meals and there was room for further improvement to the food choices available.

It was not always clear how consent had been sought from some people.

Is the service caring?

Inadequate

The service was not consistently caring.

People were not encouraged to be independent in all areas and some restrictions had been placed on people's freedoms in their home.

The local safeguarding authority made us aware that some people had raised concerns about the way they were treated in

the service.

Staff did not always engage well with people and language barriers contributed to this. Staff were polite and supportive at other times during the inspection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning was not person –centred and did not reflect people's individual personalities.

No complaints had been received by the provider but some people had raised concerns about their experience of the service to the Local Authority.

There was a choice of activities on offer and people said they could join in with these, go out alone or stay at home.

Is the service well-led?

Inadequate

The service was not well-led.

There had been inadequate oversight by the provider to highlight shortfalls in the quality and safety of the service.

Risks to people had not been appropriately assessed, monitored and mitigated.

Quality assurance auditing had been ineffective and records had not been properly maintained.

The provider had not notified the CQC of a police incident.

Some improvements had been made recently but greater input was needed to ensure that any remaining restrictive practice was changed.

Feedback had been sought from people and their relatives.

Tosh 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 25 April 2017 and was unannounced. The inspection was carried out by two inspectors. We did not ask the provider to complete a Provider Information Return (PIR), because the inspection was brought forward due to concerns received from the local safeguarding authority. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was gathered during the inspection. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with all five of the people who lived at Tosh Lodge. Not everyone was able to share with us their experiences of life in the service. We therefore spent time observing their support. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with two of the care workers and the provider.

We 'pathway tracked' all five of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at Tosh Lodge. One person told us "I have no worries or concerns and I'm happy living here". Another person said "I don't need to lock the door of my bedroom as I trust everyone here".

Our findings about safety did not agree with the positive feedback people gave us during the inspection.

Some risks to people had been identified but guidelines to reduce risks were not always available or were not clear. Where people had epilepsy or diabetes, there was limited information available to give staff guidance on what to do if people had a seizure or their diabetes became unstable. The information about epilepsy was very general and staff had not received training on what action to take if a person had a seizure. When we spoke with staff about what they would do in this situation, one staff said that they would "Put something in the mouth to stop them biting the tongue". This answer did not follow the guidance and there was a risk that the appropriate action would not be taken and people would not be supported safely. When people had diabetes they were encouraged and supported to make healthy life style choices and attended regular checks with their doctor. However, there was no guidance in place to inform staff what signs and symptoms they should be looking for if people's condition became unstable; and the action they should take. Staff had not received training in diabetes. There was a risk that staff would not take the appropriate action if people became unwell. The provider told us they would access epilepsy and diabetes training for staff and ensure full guidance and information was available as a matter of priority.

Sometimes people could display behaviours that challenged. Risk assessments identified this and said that staff should inform the provider immediately, but in some assessments there was no information or guidance for staff about what action they needed to take at the time. One person had recently gone out on their own and had been gone for a long time so staff called the police. The person had been taken to hospital because they had been unable to say who they were and where they lived. There was no assessment about the particular risks to this person when they were out alone, but a recent assessment stated that due to a history of unprovoked aggression they had agreed to be escorted on outings outside the service. The provider told us that they were in the process of updating care plans and assessments but in the meantime some risks remained unaddressed. In other people's risk assessments however, there was more detailed information about the action staff needed to take.

The provider had not carried out all the necessary checks to make sure people lived in a safe environment and that equipment was safe to use. Water temperatures throughout the service had not been regularly measured to make sure they were within safe limits. We asked the provider to check the water temperature in the main bathroom as it felt too hot. There was no adequate thermometer at the service to check this. The provider told us that the water temperatures were within the required limits as a special regulator was set at a safe level. We checked the water temperature with a thermometer used for people. It went up to 43 degrees centigrade which the highest reading the thermometer could record. This was not an accurate reading but it indicated that the temperature exceeded the recommended limit of 42 degrees. The provider said they would purchase an accurate thermometer. They contacted us after the inspection to say that a

plumber had visited and rectified the issue. We attempted to check the temperatures of the water supply to sinks in two people bedrooms but there was no hot water to enable us to do so.

The lack of appropriate actions to minimise risks to people is a breach of Regulation 12 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems designed to protect people from abuse or harm had not been operated effectively. Although the provider had a safeguarding policy and staff had received training about how to identify and report suspected abuse, we found occasions when appropriate actions had not been taken. For example, the notes in one person's care file which recorded that they had been found with unexplained bruising and swelling to an area of their face almost a year ago. There was a further entry in the notes about similar injuries six months earlier. No incident reports had been completed about this and the provider confirmed that the injuries were not discussed with the local safeguarding authority. This meant that no consideration had been given to whether an investigation might be necessary to check that the person was safe. The provider told us that they had not been aware of the injuries at the time and may have been on holiday when the incidents occurred. They also said that they had never had cause to raise any safeguarding alerts to the local authority. Following the inspection, the provider told us that they had found records of these incidents/accidents, however these had been unavailable to us during the inspection, despite our requests.

The lack of robust safeguarding practices is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people were given medicines on a 'when required' or 'PRN' basis; for example inhalers. There was no written guidance for people who needed PRN medicines. There was a risk that people may receive their PRN medicines inconsistently. People went out and about during the day but their PRN medicine was left at the service. They may have needed this medicine when they were out. There was a risk that people would not receive their medicine when they needed it. Most medicines were pre-packed by the pharmacist on a weekly basis and it was easy to make sure people had these medicines. Other medicines were stored separately in the cupboard. These medicines were not dated when they were opened to ensure staff were aware that these items may have to be used within a certain period of time. There was a risk that staff may not identify that these medicines were going out of date. The provider told us that they would address these issues immediately.

The failure to assess and minimise risks associated with medicines is a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were procedures in place to make sure that people received their regular medicines safely and on time. People's medicines were managed by staff and one person told us "I prefer staff to give me my medicines as I have to take quite a lot of tablets". Other people were being supported and coached by staff to take their medicines more independently but there was no guidance in people's care plans about how to do this. There was a risk that support would be inconsistent. This is an area for improvement.

People said they were happy with the arrangements and this was the way they preferred to have their medicines. All medicines were stored securely for the protection of people. People told us that they received their medicines when they should and felt staff handled their medicines safely. Medicine Administration Records (MAR) charts showed that people received their medicines according to the prescriber's instructions. People's medicines were reviewed regularly by their doctor to make sure they were still suitable. Staff had received training in medicine administration.

The provider had procedures in place for when new staff were recruited, but these had not been consistently followed. A new staff member had recently joined the service and they had no previous experience of working in care. The provider was waiting for a Disclosure and Barring System (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The staff member had started working at the service and for the first few weeks had been shadowing experienced staff. The provider told us they would not work unsupervised until their DBS check had been seen. However, we found that on three occasions towards the end of April 2017 the staff member was on the duty rota as working unsupervised at night. At the time of the inspection the staff member had completed one shift unsupervised. Until the DBS clearance was received the provider could not be sure that this staff member was suitable to be working with people. The provider said they would ensure this staff member did not work any further shift unsupervised until their DBS check arrived.

Other relevant safety checks had not been completed before staff started work. Some application forms did not show a full employment history and gaps in employment had not been explored when staff were interviewed. There was a risk that people were receiving care and support from staff who may not be suitable to work with them.

The failure to follow safe recruitment processes is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were emergency and contingency plans in place. Regular checks were carried out on the fire alarms and other fire equipment to make sure it was working. There were emergency evacuation plans in place in case a fire did occur. Staff and people were regularly involved in fire drills to make sure people were aware of how to leave the building safely in case of a fire. However, staff training records showed that staff had not received fire safety training. The provider said that all staff received fire training as part of their induction and during monthly fire drills. People told us how they would leave the building in the event of a fire. Each person had a personal emergency evacuation plan (PEEP) in place for the day but not for the night. There was currently no evacuation plan for night time when there was less staff on duty. The provider agreed to address this, as this was an area for improvement. Regular maintenance checks were made on other systems like the boiler and the electrics and gas supply. All upstairs windows had restrictors fitted to ensure that they could not be opened too wide and pose a risk of people falling from them.

People said that there was enough staff working at the service to support them.The number of staff on duty during the day had recently increased. One person commented, "There is enough staff on duty and you can speak to them and they give you time to have a conversation" and another person told us "There is always staff in the house day and night in case you need anything". Staff told us they thought there was enough staff on duty as they said they had time to spend with people and there were staff available to take people out if they wished to be accompanied. Most people were able to go out on their own and confirmed that there was staff based at the service whenever they came back home. One person told us "The front door is locked when we come back home, but you only have to ring the bell. There is someone here to let you in. They are getting everyone keys but I don't want a key". The duty rota indicated that there were consistent numbers of staff available throughout the day and night.

Inadequate

Is the service effective?

Our findings

People told us they were "Happy" living at Tosh Lodge and that they "Liked" it. One person said "It's good living here. I like it and can come and go as I please".

People had a wide range of needs and some people's conditions were more complex than others. There were shortfalls in staff training especially related to people's specific needs. Staff had not completed all the training they needed to make sure they had the skills, knowledge and competencies to meet all people's needs. For example, some staff had not completed mental health training; which was the main reason people lived at the service. People were at risk of receiving inappropriate or ineffective care because staff had not received training to support them in carrying out their roles. The training matrix provided to us indicated that some staff had not received fire training and other staff required refresher training in medicines administration. The provider was in the process of changing the organisation which provided training packages to them and was developing more comprehensive training for staff.

Staff had not received training about epilepsy and diabetes and there were people living in the service with these conditions. Staff did not know the signs and symptoms to look for if people's diabetes became unstable. Staff were not able to explain the correct action to take if someone had an epileptic seizure. There was a risk that people may not receive the care and support that they needed as staff had not completed the necessary training. These were important and relevant areas of training needed to support people safely and effectively. The provider agreed that there were shortfalls in staff training and said they would source the courses that staff needed.

Staff did not have the appropriate skills or experience to support people safely. Staff did not have any prior experience of working with people with mental health conditions and were not competent to do so. Most staff had come from roles outside the care sector; for example one staff had been a waiter, another a hairdresser and a third had worked in packing. People living in the service had complex and specialist needs about which staff had no previous knowledge or understanding. Staff were not able to accurately tell us about people's individual needs and conditions. This placed people at risk of receiving unsafe or inappropriate care. Following the inspection the provider told us that some staff had personal experience of caring for others; which had not been included in their applications.

Staff had regular one to one meetings and annual appraisals with the provider. They said this was to make sure they were receiving support to do their jobs effectively and safely. However these sessions had not been wholly effective because the provider had not picked up that staff did not have the knowledge and skills to provide safe and appropriate care and support in some areas.

Staff received inductions when they started working at the service. The induction consisted of time spent going over procedures, getting to know the service and the people living there. As part of the induction period, new staff shadowed existing staff to get to know how things were done. However these existing staff members were lacking in training, knowledge and experience themselves and so were not in a position to be able to effectively mentor new staff.

The lack of proper training, induction and effective supervision is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's health care was not always effective or sought from the most appropriate professional source. One person's condition had changed suddenly around three years ago and had not improved. There were no records in this person's care plan about this change and any circumstances around it. The provider told us that they had spoken with the person's doctor but other specialist professionals had not been involved to assess and support the person. As a result this person had not been assessed and any treatment options discussed and agreed with them.
A referral was made for this person following our inspection but the provider had missed earlier opportunities to seek advice about how this person could be best supported.

The failure to meet people's needs is a breach of Regulation 9 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People attended regular medical and dental appointments. One person told us "The staff offer to come with me on hospital appointments but I prefer to go on my own". They told us how they had been supported by staff to eat healthily to lose weight and take regular exercise. They said they felt a lot heathier than they had been in a long time. A doctor who had regular contact with people told us that the provider and staff knew people well and made sure they attended necessary appointments so that their health was regularly assessed.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. The provider told us that all people had capacity to make their own decisions. However, the provider had not considered if some people's capacity to make choices might fluctuate during times when their mental health declined. It was not always clear that people had given their consent to certain aspects of their care and support. For example, one person's care plan said that their medicines must be administered by staff at all times, but there was no record of how this person had agreed to the arrangement

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).The provider had not made any applications for DoLS because they said, all people had capacity to make their own decisions; including about living in the service. However, there were unnecessary restrictions in place in some areas which prevented people from being able to enjoy freedom of movement and to exercise their right to do what they wished. For example, one person told us that the provider did not wish them to drink coffee, because of her own belief that this was unhealthy. People only drank tea during the inspection. Another person said that they were not permitted to open certain cupboards or the larder fridge, or prepare their own breakfast; and signs on cupboards and the fridge showed they were for staff use only or that people had to ask before they could access them.

The failure to seek people's consent about all aspects of their care is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We received mixed feedback from people about the meals available in the service. Some people said the food was good and others that it was "Not great and I don't like most of it" and so they preferred to buy their own meals out, whenever possible. People told us that more options had been added to menus very recently to give greater choice. However, they said that the same options were offered on the same days

each week, for example cereal for breakfast on Mondays, Crumpets on Tuesdays, porridge on Wednesdays. One person told us that it would not be possible to ask for crumpets on another day because staff would not have them available. This is an area for further improvement.

Mealtimes had recently been made more flexible and menus showed that meals were available for longer periods than previously. People said that they used to have to have breakfast between 8am and 9am but could now have it later if they chose to. The same applied to lunch and dinner. People bought their own snacks to eat between meals but there was fruit and cheesy biscuits in bowls in the kitchen if people preferred to have those. People made their own cups of tea whenever they wished.

Inadequate

Is the service caring?

Our findings

One person told us "The staff are very supportive. They always ask how I am feeling and what am I doing. It's the little things that make the difference". Another person said "The staff put me first". However, the local safeguarding authority made us aware that before and after our inspection, some people living in the service had told them they were not completely happy with the way it was run and did not always feel able to speak out about their concerns.

Some people referred to the provider as 'The boss'. One person said they had to check things out with 'the boss' first, before they could do things like having the T.V. on late at night. They said "We are not allowed to go in some of the cupboards in the kitchen as the boss would tell me off". Some of the cupboards in the kitchen had labels on to say 'Staff only' or 'Hands off please' and there was a sign on the fridge which read 'Staff access only. Please ask staff if you need anything from the fridge-Manager'.The provider told us that this was to prevent food contamination if people had not observed good hand hygiene. Tosh Lodge is people's home and these restrictions did not respect people's freedom to treat it as such and was undignified for them.

People were not always encouraged to be as independent as possible. People told us that they did not get involved in any household tasks such as cleaning and clothes washing. Some people said that they could do some food preparation and cooking but that this had only happened recently. Similarly they said that they had only been able to make their own hot drinks "In the last two to three weeks". We asked one person if they would be able to help themselves to breakfast but they replied that although they were capable of doing so they were not permitted to take breakfast items from the cupboards. Activities which could help rehabilitate people like completing everyday household tasks had not been consistently promoted and their independence was unnecessarily restricted in some areas.

There was little evidence to show that people were involved in decisions about their care. In some cases people had signed risk assessments to confirm that these had been agreed with them, but in others there was nothing to confirm that care plans, risk assessments and choices had been discussed and agreed.

The failure to provide appropriate care and support is a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were able to go out alone and they did so during the inspection. One person told us "I can come and go as I please". We heard how some people chose to go out with others while others preferred to go out on their own. One person remarked "You can go out and come back whenever you want too, so long as you give them [Staff] a rough time. Otherwise they would worry".

Many of the staff working at the service had English as their second language and at times it was difficult for interactions to be spontaneous. We observed two staff taking turns to play pool with a person and there were long periods of silence with no attempts by staff to engage the person. At other times however, staff spoke quietly and calmly with people and supported them as they got ready to go out. People appeared

comfortable and relaxed around staff and each other. It was clear that people cared about and looked out for each other. We observed one person giving gentle guidance to another, and another reminding a person that their favourite television programme was due to start.

During the inspection staff were polite and pleasant and respected people's privacy by knocking on bedroom doors and waiting to be invited in. Staff then explained why they were there. When staff or the provider wished to discuss a confidential matter with a person they did not do so in front of other people but asked the person if they could speak to them in private. Feedback we received from the local authority however, indicated that people's privacy and dignity was not respected like this at other times.

The provider's terms and conditions document stated that 'Visitors are always welcome in the home and there are no restrictions on visiting times'. The local safeguarding authority made us aware that concerns had been raised with them about restrictions being placed on visits from people's relatives; who said they had been asked by the provider to leave their passport with her when they took their loved one out for the day. The provider told us that this had not happened. The local authority were investigating this matter but had not reached any conclusions at the time of our inspection. One person told us "My family visit regularly. They ring me to let me know they are coming and I let the staff know out of courtesy".

Requires Improvement

Is the service responsive?

Our findings

Care planning was not person-centred. There was scant information in people's care files to show anything about their individual personalities or the things and people who were important to them. There was some information about people's past lives but this centred mainly on the progression of their mental health conditions rather than being about people's families, careers and any hopes or goals for the future.

There were limited details about people's preferred routines and how staff should support them with these. Some of the records about people's wishes, likes and dislikes, differed from what people told us about themselves. For example, one person told us that they always woke early and got up around 6am, but their care plan said they got up at 8am. Another person explained that they really disliked spicy foods but their care file recorded that they had no particular preferences about what to eat. There was a risk that not all people would not receive support in the way they liked it because information for staff was incorrect or not recorded.

Care plans had not been regularly updated to ensure that they contained the most current information about people's needs. For example, one person's care plan made no reference to an important change in their condition which had happened suddenly and had not been updated to detail how this change affected the person's day to day care and communication about it.

People said that they went to bed early, between 8pm and 9pm; "Because there's nothing better to do". We asked if people could perhaps stay up later to watch TV or do other things and they replied that they could only do so if they gained permission from 'The boss'. People living at Tosh Lodge were all adults and should be able to stay up and do whatever they wished.

The failure to provide person-centred care planning and support is a breach of Regulation 9 (1)(a)(b) Of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people went to regular activities outside the service. These included trips to the local library, Umbrella club and bowling, when staff accompanied them. People told us they could choose to join in with the organised activities or do their "Own thing". Some people liked to go shopping or to restaurants and coffee shops alone or with another person they were friends with from the service. People told us they enjoyed the library because they could read or use computers there before having lunch in the restaurant on site. One person said that the Umbrella club was not for them but others told us that they had fun there.

People said they could choose remain at the service while others went out. Sometimes people decided to remain in their rooms for longer periods of time. Staff encouraged them to come to the communal areas to socialise and eat their meals but respected their wishes if they chose not to do so. If people wanted to be on their own staff respected this and there were opportunities for them to engage in activities at other times to prevent them from becoming isolated.

During the inspection people said that they felt listened to and their views were taken seriously. However,

the local safeguarding authority made us aware that before and after our inspection, some people living in the service had told them they were not completely happy with the way it was run and did not always feel able to speak out about their concerns. People had been asked by the provider if they were happy with everything and recent survey returns showed that every person had recorded that they were content will all aspects of the service. There was a mis-match between what people told us and what they had told other stakeholders.

There was a written complaints procedure but this was not very accessible to people as it was covered by other documents on a notice board. This is an area for improvement. The complaints procedure explained how people could complain and set out timescales for investigation and responses by the provider. There was a complaints box in the hallway where people could raise any concerns they had. There had been no formal complaints made in the past 12 months. The provider said that any complaints would be logged and investigated and responded to by them.

People had not always been encouraged to develop relationships. One person told us that visits from family or others had to be "Cleared with the boss" and could not happen unannounced. The provider's terms and conditions document stated that 'Visitors are always welcome in the home and there are no restrictions on visiting times'. The local safeguarding authority made us aware that concerns had been raised with them about restrictions being placed on visits from people's relatives. However the provider said that this had not happened.

Inadequate

Is the service well-led?

Our findings

The service was managed by the provider and had not been well-led. There had been a demonstrable lack of oversight by the provider, which had resulted in shortfalls in the quality and safety of the service going unchecked.

People told us that they had to ask permission of 'The boss' [The provider] before they could stay up after 9pm or to open certain cupboards and the main fridge in the service. We found evidence to support this and these areas were indicative of a restrictive culture; which was not appropriate and needed immediate improvement action to be taken by the provider. Staff did not understand that people should not be prevented from accessing cupboards and fridges in their own home and should have the freedom to stay up for as late as they wished, without permission. Staff had worked in line with the provider's example without questioning some practices; which had developed into a poor and inappropriate attitude towards people's rights.

Assessments about risks to people had not been supported by guidance for staff about how to minimise these to keep people safe. This applied where people had conditions such as epilepsy and diabetes or when people sometimes showed behaviours that challenged. The lack of information available to staff, coupled with the fact that they had not received specific training in these areas created a risk to people's health, safety and well-being. Staff had not received vital training about the mental health conditions people lived with in the service and the provider had not recognised the importance of this learning during staff supervision sessions.

Other risks had not been appropriately addressed, for example around excessive water temperatures and night time fire evacuation instructions. These environmental risks should have been identified by the provider and remedied.

The provider had not considered the potential risk to one person of leaving the service without their PRN inhaler medicine, until we raised it during the inspection. Unexplained bruising and swelling to one person's eye area had not been properly documented by staff on incident reports or brought to the attention of the local safeguarding authority. Robust auditing and oversight by the provider would have highlighted these issues and provided an opportunity for improvements to be made.

The failure to assess, monitor and mitigate risk is a breach of Regulation 17 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There had been no effective quality assurance monitoring by the provider. Our findings throughout the inspection highlighted areas where safety and quality had been compromised, but had not been picked up or addressed by the provider. For example; medicines audits had been carried out regularly and included checks to see that PRN protocols were in place. We found that they were not but this shortfall had not been recognised by the provider. Although routine testing of appliances, maintenance and the premises were undertaken, these checks had not highlighted that water temperatures were too high and posed a risk to

people, staff and visitors.

The failure to operate effective quality auditing is a breach of Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some records about people's care had not been updated to include changes to people's needs and so were not an accurate reflection of the current situation. For example; the latest entry in one person's care plan about aggression, said that they should be accompanied by staff when outside the home because of this type of behaviour. However, we also saw a record which showed this person had been out alone recently. The registered manager told us that the situation had changed but the care plan had yet to be updated to show this and to record how this person's aggression had been assessed as no longer a risk. The lack of up to date records could lead to this person not receiving the support they needed.

The failure to maintain accurate and contemporaneous records is a breach of Regulation 17 (1)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During the inspection we read about an incident in which the police had been involved, because staff had called them when a person failed to return to the service at the expected time. Such incidents must be notified to the CQC without delay, but the provider had failed to do so. They said that they were not aware of the requirement to make a statutory notification in these circumstances, but should have been aware of their responsibilities as a registered person.

The failure to notify the CQC is a breach of Regulation 18 (1) (2) (d) of the Care Quality Commission (Registration) Regulations 2009.

Following involvement from the local safeguarding authority and the recent inspection of the provider's other service; some improvements had been made around enabling people to do more for themselves. For example, people told us they had been able to make their own drinks and become involved in food preparation and cooking in the last few weeks. There had been some changes to make mealtimes less restrictive and a slightly improved choice of food had been added. However, there was still room for greater improvement to ensure that people's independence and choice was fully promoted.

The provider had sought feedback from people and their relatives in the form of a recent questionnaire. Responses had been received from all of the people and one relative at the time of the inspection. No issues or concerns had been raised and people and the relative stated they were satisfied with the service received.

Staff told us they were supported out of hours by the provider. They said they could contact the provider day or night and were confident they would receive any support and help that they needed.