Creative Care (East Midlands) Limited

The Old Vicarage

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

Summary of findings

Overall summary

The Old Vicarage is a service based in Ollerton in Nottinghamshire. The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service is registered to accommodate up to 14 people, and there were 14 people living there when we visited. The service has two separate buildings. The main house has five people living there. Within the main house there are also four separate flats. One flat has three people, two flats have one person in each, and the fourth flat has two people. The Cottage is a separate building with two people living there. All the people living at The Old Vicarage are younger adults who have diagnoses of moderate to severe learning disabilities and other complex healthcare needs, who require an appropriately specialised service of residential care.

We previously carried out a comprehensive inspection of the service in February 2017, when The Old Vicarage was rated as Good. Before the inspection we received two notifications from the provider about allegations of abuse. One of the allegations is still subject to investigation by the local authority and the police. As a result this inspection did not examine the circumstances of this incident. In addition, whistle-blowers provided information of concern about the quality of care provided. The concerns related to the use of physical restraint, staff training, staffing levels, and potential lack of choices for people.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present on the first day of the inspection visit. The provider's nominated individual was present on the second day of the inspection visit.

People were not kept safe from the risks of avoidable harm and abuse. People were at risk of harm because risks associated with physical restraint were not identified and mitigated. Risks associated with the environment were not reduced and mitigated.

People were not kept safe from risks arising from their health conditions. Action was not always taken to monitor and respond to changes in people's health needs. People were at risk of harm because risks associated with their health needs were not identified and mitigated. Medicines were not managed safely.

People were at risk of being physically restrained when this was not proportionate or in their best interests. There were no effective safeguards in place to ensure physical interventions used were minimal and

reasonable. Consent to care was not always sought in accordance with legislation and guidance, and people were at risk of care that was overly restrictive and unlawful.

Staffing levels were not consistently sufficient to ensure people received the care and support they were assessed as needing. People received care from staff who did not have the skills or training to support them effectively. People were at risk of harm because staff did not have training to help them to understand how to effectively support people's health and care needs.

Staff spoke in a caring way about the people they supported, but this was not consistently reflected in some of the staff's actions or language. People were not consistently supported to participate in designing or reviewing their care.

People were at risk of having care that was not tailored to meet their needs, preferences and aspirations. People did not always receive support to take part in activities within the home and in their community. People were not always supported to communicate effectively.

The service was not managed well. There were failures to meet the fundamental standards in relation to safe care practices, insufficient staffing levels and staff training, planning and delivery of people's care, and following relevant legislation. Quality assurance processes to ensure people's safe care were not effective.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to these concerns found during inspection is added to reports after any representations and appeals have been concluded.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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 kept safe from the risks of abuse and avoidable harm. There were not enough staff to meet people's needs. Risks associated with the environment were not reduced and mitigated.

Is the service effective?

Inadequate

The service was not effective.

People were at risk because the provider did not support staff to develop skills to meet people's complex needs. Consent to care was not always sought in accordance with legislation and guidance, and people were at risk of care that was overly restrictive and unlawful.

Is the service caring?

Requires Improvement

The service was not caring.

Some staff practice had developed that did not demonstrate caring values. The provider had not taken action to ensure people were treated with dignity and respect. People were not consistently supported to participate in designing or reviewing their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that was responsive to their needs. People were not supported to communicate effectively. People did not always receive support to take part in activities within the home and in their community.

Is the service well-led?

Inadequate

The service was not well-led.

There were failures to meet the fundamental standards in relation to safe care practices. Quality assurance processes to

ensure people's care and the service environment were safe were not effective.

The Old Vicarage

Detailed findings

Background to this inspection

The inspection took place on 29 September and 2 October 2017 and was unannounced. The inspection team consisted of two inspectors on both days and an Expert-by-experience on 29 September. Experts-by-experience are people who have personal experience of using or caring for someone who use this type of care service. Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We had received two notifications from the provider relating to abuse allegations, and had also received information about safeguarding concerns from two other sources. We sought the views of the local authority commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. They raised concerns with us about staffing levels and training staff received.

During the inspection we spoke with two people who used the service and seven relatives. Not all of the people living at The Old Vicarage were able to fully express their views about their care, so we spent time observing how people were supported by staff in a range of activities during the two days of our visit. We spoke with thirteen staff, the deputy manager and registered manager. We also received the views of two external health and social care professionals. We looked at a range of records related to how the service was managed. These included three people's care records, three staff recruitment and training files, and the provider's quality auditing system.

For this inspection, we did not ask the provider to complete a Provider Information Return (PIR). This was because this inspection was undertaken in response to concerns about the service. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

People told us they were supported by staff to feel safe living at The Old Vicarage. Relatives also said they felt their family members were safe. However, other evidence we found on this inspection demonstrated that people were not safe at the service.

People were not kept safe from the risk of abuse. One person experienced disrupted sleep patterns. Staff said the person was not allowed to sleep during the day, and was denied access to comfort objects during the day to reduce the risk of them falling asleep. Staff told us, and records showed there had been a recent period where the person had gone without sleep for a period of approximately 48 hours. The person wanted to sleep during the day, but was prevented by staff. There was no evidence in their care records how or why this decision had been made. There was no risk assessment or plan of care in relation to how the person should be supported to manage their sleep. The provider did not ensure that people were protected from acts which amounted to abuse or improper treatment.

There were no effective safeguards in place to ensure physical interventions used did not amount to improper treatment. For example, one person's care plan and associated risk assessment did not specify how many staff should be involved in physical restraint. Staff said up to three of them had been involved in supine (floor level) restraint, and expressed concerns about safety. Records confirmed supine restraint was used with the person. There was no evidence that supine restraint had been assessed as appropriate for this person. This put people at risk of harm from unsafe restraint techniques.

Action was not taken to identify and address incidents of a safeguarding nature. For example, staff told us and records confirmed there had been incidents of physical altercations between two people. We witnessed one incident, and inspectors had to take action to ensure both people were safe. Staff told us and care plans confirmed staff should be aware of the whereabouts of both people to prevent such incidents, but this was not the case on our inspection. Staff did not recognise these incidents as safeguarding issues, and appropriate referrals had not been made to the local authority. Management reviews of records had not identified that these incidents were placing people at risk of harm from abusive behaviour. People were at risk of harm because action was not taken to recognise when people were at risk of abuse and steps were not taken to mitigate future risk of abuse. Following our inspection, we made safeguarding referrals for seven people living at The Old Vicarage. These are still being investigated by the local authority.

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

People were not kept safe from risks arising from their health conditions. One person had mobility needs, and staff told us these needs had changed. The person needed to use equipment to help them remain safe. Staff told us, and records confirmed the risks associated with the changes in the person's mobility, and the use of equipment, had not been assessed. The person's care plan had not been updated since January 2016 to include information about how risks should be mitigated. A second person had a diagnosis of epilepsy. Their health and well-being risk assessment and associated care plan did not contain any detail about what

specific risks were associated with their epilepsy, for example, when bathing. Staff told us that the person liked to have daily baths, and that staff would monitor them from either inside the bathroom, or just outside the door. Although staff we spoke with were aware of risks associated with epilepsy and bathing, these were not recorded to ensure all staff knew how to consistently reduce the risks. People were at risk of harm because risks associated with their health needs were not identified and mitigated.

People were not kept safe from the risks associated with behaviours which presented challenges to staff. For example, staff and records showed one person's behaviour had changed, and this behaviour put other people at risk of harm. There was no risk assessment or care plan to provide staff with clear information about how to support the person when these behaviours occurred. People were at risk of harm because risks associated with their care needs were not identified and mitigated.

People were not kept safe from risks associated with the environment. Staff told us about and showed us an area which contained trip and other hazards. They said this was an area where they carried out physical restraint on one person. Staff said and records confirmed falls happened during restraint due to trip hazards. For example, on 13 and 21 September 2017, the person and staff involved in physical restraint fell over objects left on the floor in this area. No action had been taken to mitigate the risks associated with the environment, and this placed people at risk of harm.

Action was not always taken to monitor and respond to changes in people's health needs. For example, one person was prescribed medicine for use on an 'as required' (PRN) basis should they become constipated. Staff responsible for administering medicines told us other staff would inform them about when the person might need this medicine. Records showed the person had not had a bowel movement for eight days (21 to 28 September 2017). Staff responsible for medicines were not aware of this, so PRN medicine had not been given. The person's care plans and medicines records did not have guidance for staff on when to administer this medicine. The person was at risk of harm because staff did not monitor their bowel movements and take action when needed.

People's medicines were not managed safely. One person's medicine records showed a discrepancy between the pharmacy instructions and the instructions on the medicine administration record (MAR). The same person's medicine records contained a hand-written entry that did not meet current professional good practice guidance. This guidance seeks to ensure hand-written records are checked and signed by a second staff member to ensure the record is accurate. The record we saw had not been checked and signed by another staff member. This meant there was a risk that pharmacy instructions were not transcribed accurately. Another person was prescribed a medicine on a PRN basis. There was no protocol or guidance in relation to how and when staff would know if the person needed their medicine. Topical creams were not always clearly labelled. We found a topical cream which did not have a pharmacy label and therefore it was not possible to tell who it should be administered to. People were at risk of not having their medicines as prescribed.

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

Sufficient numbers of staff were not available to ensure people received the care and support they needed. People and relatives we spoke with felt there were enough staff to meet their needs. However, other evidence we found indicated this was not always the case. Staff told us there were times when there were not enough of them on shifts to keep people safe and meet their needs. Staff also expressed concerns that people were not always supported to take part in community based activities because staff were not available. The local authority's quality monitoring visit on 7 September identified concerns there were not

always sufficient staff at the service. Staff and the registered manager told us there should be 12 staff on an early shift, 12 staff on a late shift, and four staff were required at night. We looked at evidence of people's assessed staff needs and the provider's records of staff on shift for August and September 2017. This showed there were times when there were insufficient staff on shift to meet people's needs. For example, on 19 August 2017 there were seven staff on the late shift and two staff on night shift. We asked the registered manager to provide records of planned and actual staffing levels for August and September 2017, but were told these records were not kept. Following the inspection, the provider advised that although many shifts were planned with the correct staffing levels, staff were often sent to work at the provider's other locations. The provider could not consistently demonstrate there were sufficient staff on shift to ensure people's needs were met.

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

We identified concerns associated with the management of fire prevention mechanisms in the building, and passed these to Nottinghamshire Fire and Rescue Service who undertook their own inspection. They confirmed they had no concerns about how fire safety systems were managed by the provider.

Inadequate

Is the service effective?

Our findings

Consent to care was not always sought in accordance with legislation and guidance. 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's consent to care was sought for most daily personal care activities. However where people lacked capacity to consent to aspects of their care, the MCA was not consistently followed. For example, one person wore a specific type of clothing to restrict access to their continence products. There was no evidence the person's capacity had been assessed in relation to this, or that the principles of best interest decision making had been followed in accordance with the MCA. The provider had sought DoLS authorisations appropriately for people. However, the provider could not demonstrate that the restrictions in service users' care were regularly reviewed to ensure they complied with the MCA. The provider was not working in accordance with the MCA, and service users were at risk of care that was overly restrictive and unlawful. For example, seclusion was used to manage the behaviour of one person. Staff confirmed they used seclusion in one area of the building, and monitored the person via a window in the door to the area. Records confirmed this was the case. For example, the person was locked in a corridor area on 5 and 11 September 2017, and was unable to leave. The use of seclusion was not assessed for risk, planned for, or reviewed. One staff told us the person had a Deprivation of Liberty Safeguards (DoLS) authorisation in place, which made the use of seclusion acceptable. This demonstrated staff knowledge of DoLS was insufficient to ensure people's rights were upheld. The provider's nominated individual was unaware of the use of seclusion for this person. The provider was unable to demonstrate that the use of seclusion was part of the person's planned care. There were no safeguards in place to ensure people were not at risk of harm from the use of seclusion. This placed them at risk of harm, through the improper use of seclusion.

People were not protected by effective safeguards to ensure physical interventions used were minimal and reasonable. Staff told us and records confirmed that three people were subject to acts of physical restraint intended to reduce the risk of harm to the person. We saw staff support a person with a physical intervention to manage their behaviour. Staff told us and records confirmed that this type of physical intervention had not been risk assessed, and there was no guidance for staff to follow to ensure the physical intervention was appropriate, safe or necessary. Care records did not consistently provide information about what types of physical intervention may be used or how many staff should be involved in different physical interventions. Two people were on occasions restrained by staff in a supine position (lying on the floor). Staff did not know how many staff were required to safely support people in this restraint. Incident records showed the number of staff involved supine restraint varied between three and five. Care plans did not state how many

staff were needed to safely use supine restraint, and there was no risk assessment for this. The provider's policy on the use of physical intervention clearly stated risks should be identified and clearly documented, and they were not. Staff told us individual incident forms where restraint was used were reviewed, and records supported this. Staff said they did not always have a debriefing session following restraint used to review and learn how support could be more effective. There was no system in place to review and update people's care plans following incident where physical intervention was used. This meant there were no effective safeguards in place to ensure acts intended to control or restrain service users were a proportionate response. People were at risk of being restrained when this was not proportionate or in their best interests.

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

People received care from staff who did not have the skills or training to support them effectively. Staff told us, and feedback from whistle-blowers showed there were concerns about staff's ability to manage people's behaviour in safe and effective ways. Feedback from external professionals supported these concerns.

People were at risk of harm because staff did not have training to help them to understand how to effectively support people's health and care needs. For example, 17 out of 43 staff had not received training in epilepsy and how to safely support people who experienced seizures. The provider did not have consistent evidence that they assessed and reviewed staff skills and knowledge. This meant people were at risk of inappropriate or unsafe care from staff who did not understand their health and social care needs.

Staff told us and records showed the provider used an approach called positive behaviour support (PBS). This was designed to provide people with consistent support in relation to their behaviours which could place themselves or others at risk of harm. Staff demonstrated inconsistent use of PBS techniques. For example, one person needed staff support to take part in activities that were stimulating and meaningful. Staff told us and records showed the person was not supported to have a range of activities planned with them to reduce the risk of behaviour which would be challenging. 37 staff had no training in positive behaviour support. People were at risk from ineffective care from staff who were not trained to have consistent approaches to proactively respond to behaviour which challenged them.

The provider required all staff to undertake training in techniques to cope with behaviour that may harm the person or others. This training included the use of physical restraint as a last resort, and is known as management of actual or potential aggression (MAPA). Staff said, and records showed they started supporting people before having this training. Six staff had not done MAPA training, and nine staff had not undertaken refresher training within one year, as required by the provider. The provider's policy stated only staff who had attended appropriate MAPA training should use physical intervention techniques. We saw and records showed this was not the case. We had been notified of one incident where restraint had been used and a person had sustained harm. At the time of our inspection, a local authority safeguarding investigation was underway to establish whether the person had been harmed as a result of restraint. The provider could not assure themselves that staff had the training and skills to meet people's needs, and this placed people at risk of harm.

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

People and relatives spoke positively about the food and drink available. One relative said, "It's lovely and home-made. [My family member] has a limited diet, but it has improved, and staff encourage them to eat."

Planned menus we saw had a variety of different options, and we saw people being offered choices of food for meals.

People said they had support to access healthcare appointments. Relatives also felt this was the case, and said staff kept them informed of people's health appointments. Although staff generally had knowledge of people's health needs, this was not always accurate or up to date. For example, one person needed to be offered food of an appropriate texture and size. This was advice provided by an external health professional to reduce the risk of the person choking. Staff were not aware of this advice, and the person's care plan had not been updated to reflect their needs. This put the person at risk of choking. Information about health and social care appointments and outcomes was recorded in several different places. Staff could not easily access relevant information about people's health appointments and associated key information about their changing health needs. Care plans were not always updated following health appointments. For example, one person saw their dentist on 14 April and 1 August 2017. The dental visit recording sheet for both visits noted that staff should support the person to brush their teeth in a specific way, as they had inflamed gums. The person's care plan had not been updated to reflect this. Staff and records confirmed there was no evidence that staff were following the dentist advice. There was a risk essential information was not shared appropriately, and people would not receive the healthcare they needed. The provider could not demonstrate that people were supported to maintain their health.

Requires Improvement

Is the service caring?

Our findings

People and relatives felt they were supported by staff who cared about them. Staff spoke in a caring way about the people they supported, but this was not consistently reflected in their actions or language. For example, inspectors heard staff shout at a person, threatening the withdrawal of an activity if behaviour did not stop. Staff used a range of terms of endearment or diminutives of their names towards service users. There was no evidence that staff were using terms or names that people were happy with or consented to. Care records we viewed did not indicate whether people had any views about how they preferred to be addressed. We spoke with the provider about this. They were not aware whether people's views were sought about their preferred names. However, we also saw positive interactions between people and staff during our inspection. For example, one person said, "They [staff] do care," and described how staff supported them to develop their independence in ways which were positive for them. We also saw staff providing one to one support which was kind yet respectful of the person's mood and need for space. Staff did not consistently demonstrate they supported people with dignity and respect during our inspection.

People were not consistently supported to participate in designing or reviewing their care. Staff told us people were supported to express their views and wishes about their daily lives, but this was not always supported by care records. We saw some people participated in regular reviews of their care. However, for people who were less able to communicate verbally, there was no evidence how staff sought their views, wishes and aspirations. It was not clear how relatives participated in reviewing people's care as this was not documented.

People were not given information about their care plans or reviews of care in ways that were meaningful to them, for example, in easy read or pictorial formats. The provider could not demonstrate how people were involved in making decisions about their care. This meant there was a risk people's views, wishes and aspirations were not identified, and people were not supported to have care in ways that were meaningful to them.

During the course of our inspection, concerns were raised about staff behaving in ways which other staff believed would trigger people's behaviours resulting in need for behavioural intervention (not physical intervention). The provider told similar concerns had been raised on the previous inspection, and again by staff a few months ago. Despite this no action had been taken in respect of the concerns to ensure people were always treated with dignity and respect.

Staff respected people's right to confidentiality, but were also clear when it was appropriate to share information about risk or concerns. We saw staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care discreetly. Records relating to people's care were stored securely. People's confidentiality was respected.

Inadequate

Is the service responsive?

Our findings

People did not always receive support to take part in activities within the home and in their community. One relative said, "[My family member] used to go out for walks. I don't know if they do now." Staff told us there was not always enough staff to enable people to be supported in their activities and records showed people did not always have support to access activities. For example, one person had not been supported to take part in activities that were meaningful to them for 16 out of 30 days in September 2017. This person received 1:1 support for eight hours every day to enable them to participate in daily tasks and experiences. Staff were not able to explain why this was the case. Another person received 1:1 support for 15 hours a day. In September 2017, the only outside activity they took part in was going for a drive. Staff confirmed that this was not necessarily an activity that the person spontaneously chose themselves. Staff said this person's care plans had information about a range of activities, but that they mostly interacted with sensory objects on their own. The person's care plan said they had an activity programme in place with a weekly plan, but there was no evidence of this. Staff and records confirmed that this person spent the majority of the time in the service.

People were not always supported to communicate effectively. One relative described how their family member had stopped using speech or signing to communicate. They said staff had not encouraged their family member to speak or sign. Staff were not consistently using communication support methods for people when care plans clearly identified this should happen. One person needed visual aids to help them understand the structure of their day. They also needed their verbal communication enhanced by the use of Makaton. This is a language program using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech. Staff confirmed they did not consistently use Makaton with the person, and records confirmed staff did not have training. Staff were not aware of a visual aid or timetable mentioned in the person's communication profile, and there was no evidence this was being used. Health professionals confirmed the person benefited from the use of visual material to support understanding and recall. They also confirmed there was no evidence of staff using a visual timetable, despite information about this need being recorded in the person's care files. People were not always supported to communicate with staff about their needs, wishes and aspirations. This meant there was a risk people's views about their care were not heard and acted on, and the provider did not ensure the person's autonomy and independence was enhanced.

People did not receive personalised care that was responsive to their needs and preferences. Staff did not consistently provide support in accordance with people's assessed needs and support plans. For example, one person's positive behaviour profile plan stated routine was important, and changes in or lack of routine may trigger challenging behaviours. The plan for supporting the person throughout the day did not contain details about the person's daily routine, for example, whether it was important to carry out personal care support in a particular order. Staff did not know if this was important, and their information about how the person's morning routine varied. There was a risk the person's need for routines was not being met, and this was a contributing factor to their increasing anxiety and behaviours.

Information about people's needs and preferences were not always recorded in care records. Staff told us

they contributed to updating people's care plans by sharing information with colleagues responsible for this. For example, staff demonstrated good knowledge about one person's epilepsy, and described the type of seizures and what action staff took in the event of a seizure. This information was not fully reflected in the person's care plan for epilepsy. There was a risk staff would not have a shared understanding or consistent approach to providing care. This put people at risk of having care that was not tailored to meet their needs and preferences.

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

People who were able to express their views told us staff supporting them understood their preferences for support and care. For example, on person described their preferences for getting up and going to bed at different times, and said staff respected this.

Relatives said they felt concerns or issues about care would be dealt with appropriately. Relatives knew how to make a complaint. Information was available in the office for people and relatives about raising concerns and making a complaint. This information was available in an easy-read format, which made it more accessible. Relatives also told us about relatives' meetings. One relative said, "Any concerns can be aired, and you hear feedback from other parents."

Inadequate

Is the service well-led?

Our findings

The service was not managed well. During our inspection we identified shortfalls across all of the key questions we ask about services. This included failures in safe care practices, insufficient staffing levels and staff training, planning and delivery of people's care, and following relevant legislation. During inspection the provider's nominated individual explained that quality audits of the service had not been conducted at this location for some time. They said an external consultant had undertaken an audit of The Old Vicarage on 5 September 2017. The report had awarded a rating of 'good' in all five questions CQC explores during inspection. This quality audit was not effective, and did not identify any of the serious risks which we identified during this inspection.

Audits carried out by the provider were not effective in identifying where action needed to be taken. A medicines audit dated 11 September 2017 identified PRN protocols were in place as required. During our inspection we found that PRN protocols were not always in place as required and some of those that were in place were not sufficiently detailed. The provider's health and safety audits had not identified hazards. For example, we found uncovered radiators in the main building, which put people at risk of burns. This failure to accurately monitor and improve the quality and safety of the service placed people at risk of harm.

There was no effective system in place to check the quality of people's care plans. This meant that deficiencies in care plans had not been addressed. Staff told us care plans did not always accurately reflect people's needs. Staff had variable and inconsistent knowledge of people's care, as the plans guiding them were not up to date or accurate. The registered manager told us that they were aware that care plans needed updating and said they were in the process of doing this. However no measures had been put in place in the interim to ensure that staff had access to accurate information about the people they supported. Audits carried out by the provider had not identified records were not accurate or contemporaneous, and no action had been taken to rectify this. This placed people at risk of experiencing unsafe and inconsistent support.

Systems and processes in place did not identify learning from incidents to mitigate future risks to people. The registered manager confirmed there was no overarching system or method in place to review patterns or factors in incidents to show if any changes needed to be made to people's care. There was a failure to ensure care was provided in accordance with the Mental Capacity Act 2005. During our inspection we found that adverse events occurring within the service were not all recorded in line with the provider's accident and incident procedure. Consequently we found that these incidents had not been recorded appropriately or reported and no action had been taken to investigate or learn from them. People's risk assessments and care plans were not always updated as a result of incidents. This meant that opportunities to use information to ensure people's safety were missed.

Staff understood their roles and responsibilities, but the provider was unable to demonstrate staff were trained to provide care that was in accordance with the provider's policies. The provider could not assure themselves staff had training, skills and support needed to provide care to people safely and effectively.

Staff said if they had concerns they would report them but they did not feel confident the registered manager or provider would take appropriate action. The provider had not taken appropriate action to mitigate potential risks relating to the health, safety and welfare of staff. During our inspection we received concerns that staff were at risk of harm as a result of incidents. This included incidents where physical restraint and seclusion was used. Staff disclosed that they had raised concerns before, but did not feel they were taken seriously. The management team at the service were aware of the nature of the concerns, but could not assure inspectors that any action had been taken to mitigate the risks. This meant the provider was not aware of issues where they could have acted to improve the quality of the service.

CQC contacted the provider on 25 August 2017 with concerns about the quality and safety of the service and asked them to investigate. The response CQC received from the provider was not in line with our findings on this inspection, demonstrating that investigations into concerns were not sufficiently robust. Consequently the provider failed to ensure that adequate action was taken in response to concerns.

A recent local authority quality monitoring visit identified four action points for the provider to undertake. The local authority confirmed they had given verbal feedback about this to the registered manager on 7 September 2017, as well as providing a written report of their findings. Our inspection identified that three of the four action points had not been acted on. This included ensuring the service had sufficient numbers of staff and for the registered manager to ensure all staff received MAPA training. This meant the provider had not acted on feedback received in relation to the quality of care.

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

The provider had not appropriately notified the Care Quality Commission of any significant events as they are legally required to do. For example, there were two occasions where allegations of unsafe care or abuse had been brought to CQC's attention. The provider had liaised with the local authority, who had investigated. However, CQC did not receive notifications in relation to this as required. This meant the provider was not informing CQC of significant events that occurred in the service to assist in monitoring the quality of care. We spoke with the registered manager about this, and received assurance that notifications would be made in future.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 (1) (2) (e) The provider had not notified CQC about incidents of abuse or allegation of abuse in relation to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1) People were not supported in a person-centred way which met their needs and reflected their preferences.