Autism TASCC Services Limited

Collinson Court

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

Summary of findings

Overall summary

We inspected this service on 6 and 7 January 2016. This was an unannounced inspection. Our last inspection took place on 25 and 26 June 2015 where we identified multiple Regulatory breaches. We found the service was not safe, effective, caring, responsive or well-led. As a result of our last inspection, this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

The service was registered to provide accommodation and personal care for up to 12 people. People who use the service have Autism and behaviours that challenge. Behaviours that challenge are behaviours that place a person or other people at risk of harm or reduced quality of life. At the time of our inspection 10 people were using the service.

The service did not have 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 and associated Regulations about how the service is run. A new manager had been recently recruited by the provider and they told us they were applying to register with us.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. This meant people's safety, health and wellbeing was not consistently promoted.

There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

Medicines were not managed safely and people were not protected from the risks associated with them.

Safety incidents were not always reported and lessons were not learnt after safety incidents, which meant the risk of further incidents was not reduced.

People's health needs were not always consistently monitored and managed effectively to promote their health, safety and wellbeing.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves.

We found staff did not always have the knowledge and skills required to meet people's individual care needs. Effective systems were not in place to check staff had understood training they had completed.

People were enabled to participate in activities of their choosing, but improvements were required to ensure people could participate in their chosen activities at a time that suited their individual needs.

Improvements had been made to the way people received their care and support. People were treated with kindness, compassion and respect and staff promoted people's independence and right to privacy.

Relatives were now involved in the planning and review of their relations' care. Plans were in place to enable people to become more involved in this process.

Systems were now in place to ensure people's liberty was only restricted when this had been legally authorised. Staff followed the requirements of people's Deprivation of liberty Safeguards authorisations.

The provider was now informing us and the local authority of reportable incidents in a timely manner. Staff told us they were supported by the managers and provider to make improvements to the way they delivered care and support. Complaints were managed effectively.

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's health and wellbeing were not consistently identified, managed and reviewed. Medicines were not always managed safely and there were not always enough staff to keep people safe and meet peoples agreed care needs.

Safeguarding concerns were reported to the local authority as required.

Is the service effective?

Inadequate

The service was not effective. People's health needs were not always monitored and managed to promote their health and wellbeing.

People's nutritional and hydration risks were now being assessed. However, effective systems were not in place to ensure these risks were consistently managed as planned.

Staff had made improvements in the way they were applying the Deprivation of Liberty Safeguards. However, the requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were always made in people's best interests.

Staff had completed training to give them the knowledge and skills required to meet people's needs. However, effective systems were not in place to ensure staff had understood and were applying their training in the correct manner.

Is the service caring?

Requires Improvement

The service was not consistently caring. Improvements were needed to ensure people were consistently treated in a dignified manner.

People were treated with kindness and compassion. Staff respected people's right to make choices about their care and staff supported people to make choices.

People were encouraged to be independent and people's

privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive consistent care that met their individual needs and preferences.

Relatives were involved in the planning and review of people's care and plans were in place to increase people's involvement in this process.

There was a complaints policy in place and complaints were managed appropriately.

Is the service well-led?

Inadequate

The service was not well-led. Effective systems were not in place to consistently assess, monitor and improve the quality of care. This meant that some areas of poor care were not identified and rectified by the provider.

Feedback from people, their relatives and the staff was sought to identify areas for improvement in care. Staff told us they received support from the provider and managers to make improvements to the way they delivered care and support.

Collinson Court

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 was 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 6 and 7 January 2016 and was unannounced. Our inspection team consisted of three inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service which the provider is required to send to us by law and information we had received from the public. We used this information to formulate our inspection plan.

The service was subject to a large scale investigation led by the local authority. This was due to safety concerns that professionals had identified at the service.

We spoke with seven people who used the service, but due to people's communication difficulties they were not all able to tell us about their care experiences. We also spoke with two relatives, five members of care staff, the newly appointed service manager, another manager who worked for the provider and the interim regional manager. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at five people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included quality audits, staff rotas and training records.

Following our inspection we made a number of safeguarding referrals to the local authority's safeguarding team. We did this because of significant concerns we identified with people's care.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

Risks to people's health, safety and wellbeing were not always assessed and planned for. For example, one person's mobility had significantly changed following an incident. No moving and positioning assessment had been completed to identify how staff should safely support this person to move around their home following this change in their needs. This meant staff did not have access to the information they needed to ensure they supported the person to move safely. We asked staff how they supported this person to move. The techniques staff told us differed, which also meant the person had received inconsistent care. Because the risks associated with the person's change in mobility had not been assessed and planned for, we could not be assured they had received safe and effective care.

Risks to the staffs' safety and wellbeing were not always assessed and managed effectively. Staff told us they had no effective systems to summon assistance in an emergency situation. One staff member said, "I try and shout, we used to have walkie talkies, but they connected to the taxis so we stopped using them". Another staff member said, "I think we should have panic buttons". Staff told us that when they worked in isolation in one person's apartment, they had to shout for assistance from staff in neighbouring apartments. However, people in neighbouring apartments were frequently out accessing the community which meant staff would not always hear shouts for assistance. Incident forms completed by staff showed they had sustained injuries from at least one person who they worked in isolation with. This showed the safety of staff was not always managed effectively and staff remained at risk of further harm and injury.

People did not always receive their agreed level of care in order to keep them safe and manage the risks to their health, safety and wellbeing. People who required one to one staffing at night to keep them safe did not always receive this in a consistent manner. For example, an incident form showed one person who needed one to one support at night had woken up and accessed their secure garden area in an undignified manner when their allocated one to one staff member had left them alone in their apartment. This meant staff were not there to check the person was safe and suitably dressed to access the garden at that time.

At our last inspection, we found that effective systems were not in place to ensure medicines were managed safely. At this inspection, we found the required improvements had not been made. People did not always receive their medicines in the manner they had been prescribed. For example, one person was given one of their 'as required' medicines against the agreed protocol which had been signed by their doctor. This had resulted in the person spending the majority of the day on which they received this medicine asleep, which meant the person was unable to participate in their planned activities and was unable to eat their lunch. We also found staff did not always have the knowledge or skills required to administer medicines safely. For example, we asked three staff when they would administer one person's 'as required' medicine. Only one of the three staff knew when this medicine should be administered, and records showed this person had not

received this medicine in accordance with their agreed protocol on at least one occasion. Accurate records were not always kept to show which medicines had been administered to people and when they were administered. This meant there was a risk people would receive too much of their medicines.

The above evidence demonstrates that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that safe staffing levels were not consistently maintained at the service. Staff rotas showed and the interim regional manager confirmed that the provider's minimum safe staffing levels were not met during 12 nights in September 2015 and one night in December 2015. This meant that on these occasions there were not enough staff available to keep people safe and meet peoples agreed needs. Care records showed that on four nights in December 2015, some peoples allocated 'one to one' staffing was removed from them because of the needs of another person who used the service. This meant some people did not always get the level of support required to protect them from risks to their health, safety and wellbeing. Despite this happening on four occasions, no action was taken by the provider to review staffing levels to ensure enough staff were available to keep people safe and deliver their agreed care.

We also found there were not always enough suitably competent staff available to meet people's individual needs. For example, staff rotas showed that on at least five nights during December 2015 and January 2016, no staff were on shift at night who were trained to administer one person's 'as required' medicine. This meant there was a risk that the person would not always receive their medicine as prescribed because suitably trained staff were not always available to administer it.

The above evidence demonstrates there were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found people were not consistently protected from potential abuse. This was a breach of Regulation 13 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made. Staff told us how they would recognise and report abuse in accordance with the agreed local safeguarding procedures. Records showed that suspected safeguarding concerns were reported in accordance with these procedures as required.

Inadequate

Is the service effective?

Our findings

At our last inspection, we found that effective systems were not in place to ensure people's health and welfare needs were effectively monitored, communicated and evaluated to promote their safety and wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

Care records showed that people's health care plans were not consistently followed. For example, one person's care plan showed their bowel movements required monitoring as constipation had been identified as a trigger for their behaviours that challenged. We found that accurate records of the person's bowel movements were not maintained and the information recorded in their bowel monitoring chart did not always match the information in the daily summaries of their care. Staff told us it was important to keep the monitoring forms up to date as they used this information to decide when they needed to administer the person's 'as required' medicines to help manage their constipation. The person's medication records showed the staff were not consistently following the person's health care plan. The records showed that in November 2015 staff administered the person's 'as required' medicine when this wasn't needed on one occasion. On another occasion they did not administer the 'as required' medicine when it was needed. The person's care records showed they presented with behaviours that challenged after not receiving their care in accordance with their agreed health care plan. This showed staff were not monitoring and managing this person's health care needs in an effective manner.

Another person's care records showed their seizures needed to be recorded on a seizure calendar. This was to enable staff to monitor the person's seizure activity for any changes in frequency or duration. However, we found that between 26 September 2015 and 3 January 2016, 12 seizures had not been recorded on their seizure calendar. This meant staff could not demonstrate that they were monitoring the person's seizure activity to identify changes in their seizures. This person's care records also showed that on 4 January 2016, a staff member had raised concerns about the person's seizure activity. However, at the time of our inspection, no action had been taken to escalate these concerns or seek advice from a suitably qualified health care professional. This showed staff were not monitoring and managing this person's health care needs in an effective manner.

We found that improvements had been made to the way people's risk of malnutrition was assessed and managed. Effective systems were now in place to assess and monitor people's risk of weight loss or weight gain. However, people's risk of dehydration was not always managed as planned. One person's care plan stated their fluid intake needed to be recorded and monitored following the advice from a visiting health care professional. The person's care records from 26 December 2015 to 4 January 2016 showed their total fluid intake was not being monitored as planned. Their daily fluid intakes were not totalled up to show the level of fluids they had consumed. When we totalled their fluid intakes up, the records showed they did not consume their recommended two litres of fluids on any of the 10 days. The lowest fluid intake for a 24 hour period was recorded as 300ml. This meant we couldn't be assured that their plan of care was being followed to protect them from the risks of dehydration.

The above evidence demonstrates that effective systems were not in place to ensure people's health and welfare needs were effectively monitored, communicated and evaluated to promote their safety and wellbeing. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that effective systems were not in place to ensure people were lawfully and safely restricted when this was required. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had been made.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection, we found the provider was now consistently following the required procedures under the DoLS. When people had restrictions placed on them in order to keep them safe, the restrictions were lawful.

However, we found the provider did not always follow the requirements of the Mental Capacity Act 2005 (MCA) to ensure decisions were made in people's best interests when they were unable to do this for themselves. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

One person's care records showed that staff, their social worker and relative had made the decision to administer an 'as required' medicine against the person's agreed medicines protocol that had been signed by their doctor. This had resulted in the person spending the majority of the day on which they received this medicine asleep. This had meant the person was unable to participate in their planned activities and was unable to eat their lunch. The staff had not sought advice from the person's doctor when making this medical related decision. The MCA Code of Practice states, 'Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision maker'. This showed the provider did not act in accordance with the MCA. We could not be assured that the decision the staff made was in the person's best interests or was the least restrictive option because the right people had not been involved in the decision making process. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that effective systems were not in place to ensure staff had the knowledge and skills required to work effectively at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that although some improvements had been made, more improvements were required to ensure staff had the knowledge and skills required to provide safe and effective care.

Staff told us and records showed that additional training had been provided and completed since our last inspection to help them carry out their roles. We saw that some of this training had been effective in making improvements to people's care. For example, two staff members told us that participating in cultures and attitudes training had given them a better understanding of people's differences and individual needs. One staff member said, "It made me realise we make assumptions about people. It got me thinking about how people live and what makes them happy and sad. I think it was really useful".

However, we found that effective systems were not in place to ensure staff had understood and were applying their training correctly. For example, we found that some staff had not understood the training they had received that showed them how and when to administer Buccal Midazolam (a rescue medicine given to help manage some seizures). We asked three staff when they would administer one person's 'as required' Buccal Midazolam. Only one of the three staff knew when this medicine should be administered, and records showed this person had not received this medicine in accordance with their agreed protocol on at least one occasion. The interim regional manager confirmed there was no formal and on-going system in place to check staffs' understanding and application of the Buccal Midazolam training. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we were unable to identify if people could consistently choose the foods they ate and we found that staff were not always aware of people's food preferences. At this inspection, we found that improvements had been made, Staff were aware of people's dietary likes and dislikes and pictorial menus were now being used to help people make meal choices.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we found that staff did not always treat people in a caring and dignified manner. People's independence was not always promoted and people were not always encouraged or supported to make decisions about their care. At this inspection we saw the required improvements had been made by the staff, but further improvements were required by the provider to ensure people were consistently treated in a caring and dignified manner. For example, the provider had not ensured there was always enough staff available to care for people. This had resulted in an incident where one person had accessed their garden area in an undignified manner.

People's relatives told us improvements in care had been made. One relative said, "The clients seem much happier and content and cared for a bit more". Another relative said, "The staff are very caring, [person who used the service] is always very comfortable in the company of the staff now". Although people could not tell us about their care, we saw that people were happy and comfortable around the staff. This was evident because people were smiling and laughing around the staff. We observed people regularly approaching the staff with ease and staff were responsive to people when they did this. For example, we saw one person seek staff support as they were displaying signs of anxiety and distress. Staff immediately responded to this person by reassuring and comforting them. This had a positive impact on the person as their signs of anxiety and distress reduced.

Age appropriate language was now being used in people's care records and we saw staff spoke to people as adults rather than children. One staff member told us how they had accompanied a person to attend a routine health procedure. They told us how they explained the procedure to the person in a manner that helped them to understand what was happening, and they used age appropriate terminology. The staff member said, "[Person who used the service] asked me what the appointment was for. I explained they were going to take a picture of [parts of their body] to see if everything was okay". The information was given to the person in an age appropriate manner that reflected their understanding. We saw that this approach had helped the person understand the procedure as they consented to it.

We saw that independence was promoted. People were encouraged to participate in activities such as sweeping, mopping and cleaning with the required support from staff. Staff told us they encouraged people to be more independent and involved in independent living activities. One staff member said, "We ask people if they want to help. [Person who used the service] likes to help make tea and [Another person who used the service] sometimes just likes to watch us cook". We saw staff supporting both of these people participate in drink and meal preparation.

Although people could not tell us that they were involved in making decisions about their care. We saw staff offered and respected peoples' choices about their care. Care records showed that people could choose how they spent their time and people could choose to not participate in their pre-planned activities. For example, care records showed that one person's pre-planned activities for one day were; swimming, prepare lunch and go to the pub. However, the person chose to do some exercises at home, go shopping, watch a film and receive a visit from a family member instead. This showed the staff respected the person's

choice to participate in activities of their choosing.

Staff told us how they supported people to make choices about their care. One staff member told us how they helped people choose what they wanted to eat for breakfast. They said, "I open the cupboards and show people the foods they can choose". Another staff member told us how each person had a different way of showing the staff their preferences and choices. They said, "Everyone can tell us what they want in their own way". This staff member gave us examples to show their understanding of people's different communication styles. These examples matched the information contained in people's care records.

Staff told us about people's individual likes and dislikes and we saw that staff used this knowledge to talk and interact with people. For example, we saw a staff member talk to one person about colours. The staff member knew the person's favourite colour and talked about the things this person had in their room were that colour. The person indicated they enjoyed the conversation by smiling and responding to the staff member's questions.

The staff were aware of people's right to privacy and we saw that people were enabled to have periods of 'private time' at their request. People were supported to maintain relationships with their families. We observed staff supporting one person to participate in a community visit with their relative. The person came back from their visit smiling and laughing and their relative told us how the staff had supported them to have a, "Lovely time".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that people's individual care preferences were not always met. At this inspection, we found that some improvements had been made, but further improvements were required to ensure people's care preferences were met on a consistent basis.

We saw and care records showed that people were supported to access the community on a regular basis. A relative confirmed this by saying, "[Person who used the service] is going out a lot and doing more". Another relative said, "[Person who used the service] is getting the care they deserve now because of the improvements. They were being short changed before". We saw that people were supported to participate in activities of their choosing both at the service and in the community. For example, we saw staff supporting people to draw, participate in ball games and access the community to eat out, shop, or go for a drive/walk. Staff told us and we saw that the provider had increased the number of vehicles at the service to enable more people to access the community. However, we found that there were not always enough suitably skilled staff available to drive the vehicles. For example, care records showed that on 19 November 2015 one person's behaviours that challenged escalated because they couldn't go out into the community as no suitably skilled drivers were available to support them. This meant people did not always access the community when they wanted to do so.

We found that staff were not always responsive to people's individual and changing needs. For example, one person's care records showed they had been unwell one day and as a result of this, they had been falling asleep. Staff had recorded that they had, 'Woke them up constantly so they could have a rest at night'. This meant the staff had not been responsive to the person's need to sleep and rest when they were feeling unwell.

At our last inspection, relatives told us they were not always encouraged to be involved in the planning and review of their relations' care. Relatives also told they were not always kept up to date about changes in their relations needs. At this inspection, we found improvements had been made. Relatives told us they had been involved in the planning and review of their relations' care and they were kept up to date about any changes in their relations care needs. One relative said, "I was invited to [person who used the service] review and their social worker was also present". They told us they discussed what their relation enjoyed doing and they were asked what activities their relation may wish to do in the future. Another relative said, "It's much improved, I am now [person who used the service's] advocate" and, "The staff inform me of incidents".

Staff also told us about changes that were being made to enable people to be more involved in the planning and review of their care. Plans were in place to make care reviews pictorial to help people be more involved. Pictorial based care reviews had not yet been implemented, so we were unable to see if these were effective.

People who used the service were unable to tell us how they would complain about their care. Staff told us they hoped the pictorial reviews would help people to tell staff if they were unhappy with their care. The formal complaints policy was in display in the reception area. Relatives told us the provider was responsive

to their complaints. One relative said, "Complaints are dealt with very quickly by [The interim regional manager]" and, "[The interim regional manager] is very good, they listen to what I say and make changes". Another relative said, "I talk to the staff, seniors and managers. I haven't needed to make a formal complaint as they've sorted things out". Records showed that complaints were managed in accordance with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

Quality checks completed by the provider were not always effective in improving the safety and quality of care. A quality check dated 11 November 2015 had been completed by the provider. This had recorded 20 actions that needed to be completed to improve safety and quality at the service. No dates had been listed against these actions, to give staff the timescales required in which to make improvements. A second service review dated 30 December 2015 had been completed by the provider. This review identified that 14 of the previous 20 actions had not been completed to increase safety and quality. For example, action had not been taken to ensure fridge and freezer temperatures were being monitored and recorded to check food was being stored safely. Temperature monitoring records showed that between 11 November 2015 and 31 December 2015 the temperatures of the centrally located freezers and fridges had been checked on only six of the 51 days. The Food Standards Agency (FSA) recommends that freezers should operate at -18 Degrees Celsius. Temperature monitoring records show that on 21 and 22 November 2015 and 1 December 2015 one or more freezers fell below this recommended range. This meant we cannot be assured that food items contained in these freezers were being stored safely. This shows the action needed to address this need for improvement had not been taken and as a result people were at risk of harm to their health.

We found that medicines audits were ineffective. The concerns we identified with the management of medicines had not been identified by the provider during the last medicines audit that took place on 11 December 2015.For example, the provider had not identified that medicines were not always being given in accordance with people's agreed protocols signed by their doctor. As this had not been identified by the provider, action had not been taken to ensure peoples medicines were managed safely.

Effective systems were not in place to ensure the correct skill mix was available to meet people's individual needs. Staff records showed that between 1 December 2015 and 7 January 2016 there were at least five occasions where none of the staff on duty were trained to administer one person's 'as required' medicine. This meant the provider had not ensured that enough competent staff were available to meet that person's individual needs. As a result of this there was a risk that the person would not get their medicines when they needed them.

Effective systems were not in place to ensure there were enough staff available to keep people safe and meet peoples agreed care needs. Care records showed that four incidents had occurred in December 2015 where there was not enough staff available to provide peoples agreed level of care. The incident forms for these incidents had all been reviewed and signed off by the manager at the time, but no action had been taken to address the risks associated with staff not being able to deliver peoples agreed level of care.

Staff told us and incident forms showed they were at high risk of harm as a result of the behaviours of

people who used the service. Staff told us they had no effective systems to summon assistance in an emergency situation. The interim regional manager told us the provider had trailed the use of walkie talkies to enable staff to call for assistance, but this had been ineffective. No further action had been taken to address this risk to staff. This meant the provider was not promoting the safety of the staff as staff had no effective way of calling for assistance if they or people who used the service were at risk of harm.

We found that some incidents where people had been aggressive towards staff had not been reported as an incident. This meant these incidents were not reviewed or investigated by managers. For example, one person's care records showed they had grabbed or pushed staff on at least three occasions during November 2015. None of these incidents of aggression had been reported to the provider as a safety concern. This shows that effective systems were not in place to ensure incidents were reported and investigated to promote safety and reduce the risk of further incidents from occurring.

Consistent and timely monitoring of people's behaviours that challenged was not being completed. For example, one person's care records showed they had displayed 30 episodes of behaviours that challenged between 14 October 2015 to 31 December 2015. However, their behaviours that challenged records had not been reviewed by the provider since 29 June 2015. This meant the provider was not monitoring the person's behaviours consistently to identify any themes, trends or changes in their presentation.

People's care records were not always kept secure which meant confidential information about them was not always safe. For example, one person's care records showed that on two occasions in November and December 2015 they were, 'ripping folder and daily records' and had, 'tried to destroy their medical file by ripping it'. There was no evidence to show these incidents had been reported to the manager or provider. As a consequence no action had been taken to prevent this from occurring in the future.

The above evidence shows that the service was not well-led. Effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that the provider did not fulfil the requirements of their registration with us. We had not been notified of multiple safeguarding incidents in a timely manner and we had received no notifications to inform us that some people had authorised DoLS in place. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found the required improvements had been made. The provider was now informing us of notifiable incidents.

Although we identified significant concerns with the safety, effectiveness, responsiveness and management of the service; staff and relatives spoke positively about recent improvements in the way care was delivered. One relative said, "There have been big changes, all for the better". Another relative said, "Everything is much better" and, "It's much improved". Relatives and staff gave us examples of some of the improvements they had noted. These included, people being supported to go out into the community more frequently and improvements in the quality food.

The provider had sought feedback from people's relatives about the quality of care via a satisfaction survey. We saw the results of this survey had been analysed and the provider had started to address concerns raised by relatives.

Staff told us they enjoyed working at the service. One staff member said, "The atmosphere is nice and calming now, it's how it should be". Another staff member said, "I love coming to work, it's different every day and everyone is so supportive". Relatives also told us the staff appeared happy at work. One relative

said, "The staff seem happier". Staff told us the provider and managers had supported them to make improvements to the way they delivered care and support. One staff member said, "The manager gave me points to work on to improve. I worked hard and I got praised for that, it made me feel good". Another staff member said "I've been told I'm a very good worker, they are building my confidence up". We found this had been effective as care was now being delivered in a dignified and respectful manner.