Essex Care Consortium Limited

Essex Care Consortium - Colchester

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Essex Care Consortium Colchester is a care service providing care and accommodation for up to twenty people who have a learning disability and autism. The service was provided between two houses at the site called Birch House and Cedar House.

Cedar House provides accommodation for up to 12 people who have high dependency needs due to learning and physical disabilities.

Birch House offers residential placements for up to eight people who require a high level of support, and who are less dependent on staff for support in aspects of daily living. People living at both houses need support to achieve their potential, develop their basic skills, and access the wider community.

This is the first inspection of the service under the new ratings system. The service was last inspected on the 18 February 2014 and was found to be compliant with the regulations.

At the time of inspection, the service was caring for 16 people across two houses and had four vacancies. They employed 21 permanent staff across the two house's, seven of which were new members of staff undertaking their probation period and care certificate induction. The provider had a number of services in the near vicinity and consequently staff from their other services sometimes covered regular staff vacancies at the Birch site. The service used agency when shifts could not be filled.

At the time of inspection 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 service was rated requirements improvement overall, with an inadequate rating in safe.

The premises were not fully maintained and the environment was not clean. Risks in the environment were not managed to reduce the possibility of harm to people. Where the registered manager identified that the service did not have enough cleaning staff they had not advertised for additional staff or informed the provider. Care staff carried out some of the cleaning but staff and relatives told us this detracted from time spent with people at the service.

We observed that staff did not always manage behaviours that challenged well, and that due to a lack of understanding of how to communicate with people with these behaviours, used PRN (as required medication) to reduce people's agitation. However, staff managed regular medicines safely carrying out daily medication checks across both houses and the manager carried out regular medication audits to ensure that medicines were being administered correctly. Staff did have training in administrating specialist medication to manage epilepsy and this was in line with NICE guidance, (National Institute for Clinical

Excellence).

The registered manager carried out a variety of Mental Capacity Assessments for people at the service. However, these were not completed in line with best practice. People at the service were not supported in making decisions about their care and treatment and those who might have advocate on their behalf were not always consulted.

Staff did not always have the skills to support people with communication difficulties and behaviours that challenged in line with best practice.

People at the service were not always treated with dignity and respect. Staff did not always have the communication skills needed to support people with communication barriers and behaviours that challenge.

Care plans were not always person centred and risk management plans for non-physical health related care needs were not thorough. However, the service worked collaboratively with health and social care professionals to meet people's health needs. In addition, we saw that physical health care plans were robust.

The registered manager had not made appropriate safeguarding referrals to the local authority or to the Care Quality Commission as legally bound under the Care Quality Commission (Registration) Regulations 2009 (Part 4).

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). You can see what action we told the provider to take at the back of the full version of the report.

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 environment was not well maintained and when issues had been reported these were not always followed through.

The environment was not always clean and free from infection risk.

The service had not reported safeguarding concerns to the local authority or to the Care Quality Commission in line with their legal requirements.

However, people had good risk assessments for physical health needs and access to additional services to meet these needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff, including managers, did not have a clear understanding of Mental Capacity Act assessments.

Staff did not receive regular supervision or appropriate observations of care practices to ensure that they were competent to carry out their role.

People did not have choices of meals, in spite of the service informing us that at least two options should be offered.

Is the service caring?

Requires Improvement

The service was not always caring.

Some interactions with people were not caring and did not consider people's individual needs and preferences.

Staff did not manage people in distress in a caring manner and staff were lacking in empathy.

People were not always involved in decisions around activities.

However, management had supported people around bereavement in a caring and sensitive way.

Is the service responsive?

Requires Improvement

Care provided was not always person centred.

People were not always involved in decisions around activities.

People were not always included in decisions around their care when they might have been able to contribute.

Is the service well-led?

Requires Improvement

Managers did not use information from audits, incidents, complaints and staff feedback to drive up the standard of the service.

Staff did not receive sufficient managerial support and monitoring to improve the standards of care provided.

However, staff told us that managers were visible and approachable.

The senior managerial team immediately put into place measures to mitigate identified risks following inspection.

Essex Care Consortium - Colchester

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over two days on 12 April 2016 and 22 April 2016. The inspection was unannounced. The inspection team on the first visit consisted of an inspector and an Expert by Experience. An Expert by Experience has personal experience of using or caring for someone who uses a health, mental health, and/or social care service. Our Expert by Experience had experience of supporting a person with learning disabilities. The inspection team on the second visit consisted of two inspectors.

A third visit by an inspector and an inspection manager was carried out on 25 May 2016 to meet with the management team and the provider.

Before inspecting the service, we looked at all the information that we held about the service on our systems including notifications that the service had sent us. This is information about important events which the provider is required to send us by law.

During the inspection, we spoke with two people who lived at the service and five relatives. We spoke to the registered manager, assistant general manager and four members of care staff. We observed a handover where staff informed staff taking over a shift how people had been. We reviewed seven staff files and five people's care plans, risk assessments and nursing notes. This included information from other health professionals about the needs of people at the service. We also carried out care observations of staff and people at the service during the course of the two days.

We checked the physical environment and examined processes including how people's medicines were managed. We reviewed the service's policies and procedures relating to the management of the service and care of people.

Inadequate

Is the service safe?

Our findings

We found a communal bathroom near the living area on Cedar House with a bath full of water and the door left open. There were no members of staff present. This created a risk of harm to people who did not have the capacity to understand risks associated with water. We immediately brought this to the attention of staff and, were told that they had run a bath for a person who liked it made ready for them. The door also had a lock on the inside and there was the potential for people to lock themselves in, although staff could open the door from the outside of the bathroom with a flat key or coin, they would have to be aware that the person was in there alone. Whilst people were regularly checked, it would only need to be a short period of time for a person to be alone and placed at potential risk with a full bath. The providers own policy stated that staff should ensure that the bathroom be locked when not in use and when the bath was full.

General maintenance at the two houses was poor. The general maintenance of the environment is important, not only in regards to safety but also in regards to general mental wellbeing of the people within it. Maintenance records demonstrated that a number of maintenance issues were not addressed for some months. We saw some broken window handles. The provider informed us that the window was still accessible and safe; however, it took five weeks for the repair to take place. Some floor tiles in the corridor on Birch House had been broken and taped and we saw that blue tape had been used to make a small number of remedial repairs throughout the houses.

A person at the service liked to dismantle sockets. However, although the risk had been identified, sockets were only repaired, as they were broken. Staff told us that they taped up broken sockets and did not immediately repair them as the person dismantled them to achieve enjoyment from watching them being fixed and they wanted to discourage this behaviour. The provider told us that the electrician did isolate the power to the socket when dismantled to prevent electrocution. However, measures had not been proactively taken to box in sockets in spite of the identified risk.

High steps in place in communal hallways had not been identified as a potential falls risk and measures had not been taken to minimise the risk, for example contrasting colours to indicate a change in height. This was in spite of some people using the service being identified as having poor sight, spatial awareness and being at risk of falls.

A toy box was kept in one communal bathroom with a person's name on, but the toys and box were dirty and had lime scale on. Some of the toys were cracked and broken. Broken and dirty toys presented a risk of infection or injury.

Some people had been prescribed medicines to be administered on an 'as required' basis, for example medicines to reduce anxiety. These are referred to as PRN medicines. Medicine cards documented that some people received frequent PRN medication for behaviours that challenged. A review of staff files and the observations of staff with people who were presenting with behaviours that challenged demonstrated that staff did not always have the appropriate skills to de-escalate challenging situations without the need for medication.

When PRN medication was used to manage anxiety and behaviours that challenged, staff did not record whether the medication had been effective. We observed that behaviours that challenged were not always recorded in the handover sheet, the person's daily notes, or in the communication sheets. Staff did not always record in the daily notes whether they had sought management review of the situation. This meant there was insufficient information to assess whether the medication had been used appropriately, whether it had been of benefit and when it might potentially need to be reviewed.
This was a breach in Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), Safe care and treatment.

The cleanliness and general maintenance of the houses was poor. One medication cupboard kept in the staff room containing topical medicines and some stock was dirty. We found a sandwich box without a lid in the cupboard that contained a person's hearing aid pieces. These were covered in dust and other debris. We showed the registered manager who indicated that they did not consider it was a problem and did not understand why it was a problem, however did take measures to immediately clean the cupboard. The failure to keep a person's hearing aid clean and fit for purpose showed a lack of respect for the person's possessions. The second visit to the service we saw staff accessing this box to help the person with their hearing aid. At this time, it was clean.

In both of the house's kitchens, walls, doors, and skirting were dirty. Shared bathrooms were not clean, and in one, we found a dirty bath chair. Two relatives we spoke with told us they had expressed concerns about the cleanliness when they had visited. One said about a person's bedroom, "Staff say that they haven't got time to clean, we had to ask for [our relative] bed to be changed – it was dirty and had grit in it. There are no towels and the bathroom isn't clean." Managers told us that staff had to pick up some of the cleaning duties, although staff told us they simply did not have the capacity to do this, as well as look after people at the service. One relative said of the staff, "It's not the people themselves; there are just not enough of them."

We reviewed maintenance logs dating back to November 2015, and found that many of the issues reported by staff as urgent had not been actioned, and there was no system in place for staff to follow these up.

Staff received training in food hygiene and infection control. However, in kitchens worktops were covered in food and dirty utensils. Cutlery drawers, fridges, and cupboards were dirty. When people had been supported to use the kitchen they had not been supported to maintain good hygiene practices within the kitchen. We found this was the case during both the first and second visit to the service. This indicated that staff did not demonstrate that they respected people's home and did not model good practice when supporting people to prepare food in their home.

We brought all these issues to the attention of the management team on the first visit, who then carried out an immediate review of the environment. They told us that they did not have enough cleaners. During our second visit, they told us they had obtained a deep clean quote for the houses, and sent us the receipt once this had been carried out.

We did find the environment in a cleaner condition on the second visit, although some of the broken areas had not been fixed, such as broken floor tiles. The provider told us that they had decided to completely replace one of the kitchens as they felt it was looking tired. We also saw that care staff were cleaning communal areas whilst people at the service were attending the day centre and other activities. At the time of the second visit, the service had not recruited additional cleaning staff. However, at the provider meeting we were informed that they were actively seeking to recruit into the cleaning post. The provider has since informed us that they have recruited an additional cleaner.

This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), Premises and Equipment.

We saw that staff recorded incidents that occurred in the houses, including those where people had been subjected to aggressive behaviour from other people at the service. When triggers to aggressive behaviour towards a person had been identified, these were not managed to mitigate future risks. The registered manager had not reported safeguarding incidents to the local authority in line with best practice. They had not notified the Care Quality Commission of incidents as required by regulation.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents.

Safeguarding vulnerable adults and children training was given to staff as part of their mandatory training requirements. We spoke with four members of staff who were able to describe features of potential abuse. However, staff were not receiving regular updates in line with best practice. The service's training records demonstrated that four members of regular staff had not received the training; four staff had not received an update since 2013. However, staff from across the provider's sites would also work at the houses and in total 10 people had not received safeguarding adults training.

Staff told us that there had been a high staff turnover and that they often worked with agency staff to manage vacant shifts, which had been difficult at times, as agency staff did not always know the people at the service very well. The registered manager told us that this had been unsettling for people at the service and had affected continuity of care, however, the service had taken measures to recruit into vacant posts, and a number of new staff had recently started at the service and were in the process of induction.

Staff at the service were unable to work until they had received an enhanced check from the Disclosure and Barring Service (DBS) to confirm that applicants were not barred from working with people who required care and support. Two satisfactory references were also required and we saw that these processes were being followed.

We saw from people's care records that risk assessments were carried out according to people's individually assessed risks. Some of these risk assessments were comprehensive however, some were brief, and whilst risk was identified did not always alert staff to risk triggers and how they should manage the risk should it present.

Physical health risk assessments, however, were comprehensive and contained much more detail about signs, symptom's and interventions that included evidence based best practice guidance, for example, utilising the model of care devised by the Joint Epilepsy Council, in conjunction with advice from the community nurse specialist. These risk assessments contained clear guidance for staff on the use of rescue medicine in the event of emergencies.

The service had a PRN (when required) medication policy. This included medicines for pain relief, however did not document how pain had been assessed or whether medicine had been helpful. It was not always recorded who had agreed PRN medication within people's daily notes as per the provider's policy. PRN plans also included people had become agitated and staff had been unable to alleviate their agitation in other ways. Staff did not document sufficiently the cause of agitation or how they had attempted to alleviate the agitation and distress prior to PRN medication being used and whether the medication had helped afterward. The providers policy stated that all PRN medications used in the management of behaviour's should be documented as a "chemical restraint," however this was not always documented in peoples care

notes or in the restraint book.

Staff managed, monitored, and disposed of regular medicines safely. Staff received medicines training from the pharmacy providing the medicines every two years. The registered manager carried out observations of staff dispensing medication to ensure competency before they would be able to administer medicines independently. There were clear systems in place to monitor the provision of medicines. For example, if people required topical creams charts were available to show staff where they should apply it. Side effects information sheets were kept for individual people on certain medicines. Senior staff had been trained to administer Buccal Midazolam in line with National Institute of Clinical guidelines NICE. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Buccal Midazolam is a medication prescribed to people who have had a previous episode of prolonged or serial convulsive seizures. People requiring this medication had specific care plans in place and capacity had been documented.

Topical medicines were dated, and room and fridge temperatures had been monitored. People had their own medicines locked in a small medication cupboard in their bedrooms, which only senior staff administrating medicines had to access too. Two staff checked medication administration records (MARS) at the end of each shift and the registered manager audited these weekly.

Requires Improvement

Is the service effective?

Our findings

The registered manager undertook Mental Capacity Act assessments for people living at the service. 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.

We noted from the care records we examined that there were numerous completed forms to assess people's capacity to make day-to-day decisions. These forms are referred to MCA 1 records. The majority of these records had not been completed appropriately and they did not show whether the process followed included how the decision was made and if it was made in the best interests of the individual.

In one person's care records, we saw that 27 MCA1 forms had been completed and many of them were not relevant to the person. For example, there was one assessment relating to medication that did not contain appropriate information. One section of the MCA1 asked 'what is the exact decision you are assessing capacity for?' This record stated, "[The person] does not have the capacity to understand medication i.e. ordering or administering or returning medicines." There was no clear information as to whether the assessment being made related to the person having the capacity to self-medicate or whether to another issue such as the person refusing to take prescribed medicines. As it is the responsibility of the provider to have appropriate process for supporting people with their medicines including ordering, administering and returning them, these processes were not likely to be carried out by the person unless they managed their own medicines.

The MCA1 document contained a section to detail the action to be taken, why it was in the best interests of the person, who had been consulted and what the person's feelings were about the decision. This section did not address any of these areas and simply stated staff were to give "clear instructions" to the person, they were to follow the care plan and administer the medicine at prescribed times. We discussed these issues with the registered manager who carried out the assessments. The manager and staff at the service did not have a clear understanding of mental capacity and consent.

This is a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014, Need for consent.

Staff undertook a 12-week induction period, which included the care certificate as part of their probation period. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that these workers have the same introductory skills, knowledge, and behaviours to provide compassionate, safe, and high quality care and support. At the time of inspection, the service had recruited six new staff members for the Colchester service. During this 12-week, period staff were expected to demonstrate their competency in their role before employment would be confirmed.

New staff attended face-to-face training days at the service were they were supported to explore each of the care certficate's15 core standards. Staff completed workbooks, role-plays, group work and reflective accounts, and we saw a number of care observations, which took place for each core standard before being signed off as competent. Managers told us that they did not plan to roll this out to existing staff, however intended to use elements of the training that may not have been covered during existing staff's training.

Physical intervention training, including breakaway training, to support people with behaviours that challenged was not mandatory and not offered to staff until they had completed mandatory training. We observed in care notes, incident forms, and behavioural plans that some people had become distressed and displayed behaviours that challenged that might place themselves and others at risk. We saw that care notes demonstrated that people had grabbed others clothes, hit out at people and been escorted their room. Staff meeting minutes documented one person's behaviour becoming more complex and that staff felt vulnerable, yet not all staff were trained to manage these risks.

Care notes did not always clearly document how staff had intervened when people displayed behaviours that presented risk to others. Only five episodes of physical interventions had been recorded since November 2015. However, information in care notes documented that people had presented with these behaviours on more than five occasions. Staff did not record how they had intervened. We could not be confident that staff were recording all physical interventions, which can be defined as, "Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently (DOH, 2014)." This would include when staff would have had to escort a person to a quiet area, breakaway from a person or release a person's hold from another person or object.

On the first day of inspection, only three members of staff on duty across the houses in the morning shift had been trained in physical interventions training. The provider did have an alarm system in place that staff would use to summon assistance in an emergency, and the manager was trained and available during the regular working week. The provider told us that they organised staff rota's to ensure that enough staff were available to intervene when needed, but this included seeking support from an adjacent building. Whilst this would support planned interventions of physical intervention and restraint within regular working hours, it would not be sufficient to manage situations that required immediate intervention or that were out of hours. Consequently, we could not be confident that all staff had the necessary updates and training to do this safely.

The provider told us that part of the staff training within physical Intervention training supported staff to de-escalate and manage risks associated with behaviour's that challenged. However, as this was not mandatory training and not all staff were trained; we were concerned that not all staff had the skills to de-escalate distress. This is contrary to best practice guidelines issued by the Department of Health, which state, "All staff who may be required to use restrictive interventions must have high quality, specialised training."

Existing staff did not receive regular supervision. Some staff had not received supervision for over a year. When supervision was recorded in staff files, we saw that staff had made numerous requests for additional training in communication techniques to support their work with people at the service. However, these requests were not actioned and staff continued to make the same requests each time. Consequently, the provider had not responded to staff's request for training that would enhance the care and culture on the houses. As new members of staff were shadowing existing staff as role models for caring interventions and how to communicate with people, we could not be confident that new staff were being shown how to communicate with people appropriately.

We did see that two people had received an introduction to ICE training (Inclusive Communication Essex). However, we could not see how people's knowledge was disseminated to other members of the team. We observed some poor quality interactions between staff and people at the service, which demonstrated that training in this area was needed. We met with the provider and discussed these concerns.

The service had not reviewed their care practices alongside up to date national guidance. Senior managers provided training on how to manage complex behaviours; however, these practices were not in line with guidelines from the National Institute of Clinical Evidence (NICE) for managing people with learning disabilities and behaviours that challenge. Managers told us "We've always done it this way." This meant that they had not considered best practice regarding changes to the environment, or how staff communicated and engaged with people.

This is a breach of Regulation 19 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2014, Fit, and Proper Persons employed.

The service adhered to Deprivation of Liberty safeguards (DOLS) and people at the service who lacked capacity to keep themselves safe were protected. The deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people aged 18 and over who are, or may become, deprived of their liberty in a hospital or care home.

We saw that most people were sitting alone on different tables at meal times. The provider told us that this was due to people's choices and that some people preferred to stay in their rooms. We did observe one member of staff spending time chatting with a person about their trip to town later that afternoon. The person smiled and appeared to enjoy this interaction.

There was very little choice available for food and drink options. A menu was on display in Cedar ` kitchen but gave no indication that there were options or choices offered to residents for any of their meals. Only one meal option was displayed. On the first day of inspection, the lunch choice was a chicken nugget sandwich and coleslaw.

We spoke about this with staff who told us that people could not communicate what they liked and disliked so they only had one option at meal times. However, whilst some people did struggle or were unable to verbalise likes and dislikes, we found that staff did not always have the skills to help people make choices, which meant that individual preferences were not being considered.

Some people were able to use choice cards. People were offered water or juice with their lunch but we did not see drinks being offered at any other time, nor was there any evidence of drinks being available to people throughout the day. Kitchens were kept locked but staff told us that if people wanted a drink they would be supported to make one. Staff told us that people did not communicate choice and were unable to provide evidence about how they knew when someone wanted a drink.

We spoke to the management team who informed us that there should be two options available and that they would look into this. However, during the second visit 10 days later, there remained only one choice.

We saw that people who were at risk choking had received speech and language therapy (SALT) assessments. Care plans were in place to support people who had behaviours that placed them at risk around food. Such as wanting to constantly eat and drink which would place them at risk of choking and other serious physical health care problems. These care plans were devised in conjunction with specialist learning disability services and we saw that staff knew the care plan well and implemented the

interventions.

We saw from people's care records that they were supported to access health professionals according to their individual needs. There was evidence that people attended regular consultations with psychiatric services, visited the doctor, attended hospital appointments for procedures such as x-rays and had appointments with opticians and chiropodists. Where people required specialist support, for example around conditions such as epilepsy, they were referred to clinical specialists.

Requires Improvement

Is the service caring?

Our findings

Staff did not always treat people in a kind and compassionate manner, with dignity or respect.

One distressed person was calling for a member of staff for over 10 minutes because they required assistance with continence needs. The person became more agitated as they were left to call for the member of staff. When the member of staff finally came, the person was told in an agitated way, "I'm getting your tablets for you." We did not observe if tablets were given at this time, but there was no effort made to understand why the person had become so distressed and consequently the member of staff had not understood the link between behaviours that challenge and unmet needs behind it.

During another observation, a person approached the office calling for a member of staff. The staff members in the office ignored them. We noted how long the person called before the member of staff eventually engaged with them. After seven minutes of standing outside the office the staff member eventually told the person to "Go away [Person] I am busy," before closing the door on them. We spoke to the provider about these observations and they took measures to address these issues with staff.

There were a number of people with epilepsy at the service. We saw in one of the offices that there were two monitors with integrated cameras so that staff sitting in the office could monitor the person when they were in their room and respond in the event of them having a seizure. However, the office door was open and the monitor was in full view of anyone walking past the room. In addition, one person was in bed following an incident and their bedroom door was left open to monitor them. Again, the person was in full view of anyone walking down the corridor. This did not demonstrate that thought had been given to maintaining the person's privacy and dignity.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014, respect and Dignity.

However, we did see that after a recent death of a person who had resided at the home in the past and who had developed relationships with people at the home that staff were caring in the way that they had informed people the person had died. Managers held community meetings and people who knew the person were encouraged to talk about their life and contribute to the arrangements of their funeral, for example, what type of clothes they thought the person would like to be dressed in. A newsletter was created for people and senior managers told us that staff had spent time talking about the newsletter with people. The service had thought very hard about how to include and support people at the service at time.

Relatives told us that staff did care about people at the service. One relative told us, "They are very pleasant and have plenty to tell me about [person], they seem happy to talk to me. The only thing that I sometimes need to remind them about is to get [person] a haircut." Another relative told us, "They do seem to care about [Person] but they don't understand [Person]"

Requires Improvement

Is the service responsive?

Our findings

People and relatives were not always involved in care assessments for their needs, views, and preferences. One relative told us, "There are no regular patterns to meetings to enable input to decisions about what's best for [Person]." We saw that whilst the service had tried to implement relatives' meetings about the general running of the home, these had fallen by the wayside due to poor attendance. One relative explained that they had asked for a medication review due to their loved one's change in behaviour. However, they had not received any feedback from the managers about their concerns and the outcome of them.

Three relatives expressed concerns that their family members did not receive the individualised care and support to meet not only their physical needs but also their emotional needs and they gave us specific examples of how this affected their family member. Two relatives also told us that interests and activities that their family member had been interested in before they moved to the service had not been facilitated. They gave specific examples of how the development of independent living skills had not been promoted or encouraged.

One relative told us, "[Person] is definitely safe. There is no need for me to be involved in decisions; I go along with what they say."

Another relative told us, "All the people who live there are bored, they are always asking to go out but staffing levels are a concern, and very few of them drive." One relative told us, "I was promised all sorts in the beginning to promote [Person's] independence. These have never materialised. The only opportunities to go out involve going in the minibus with other people at the service, [Person] is too anxious to do that."

People's care plans documented the person's identified needs and what measures were in place to meet that need. The information in the records was, in some cases, quite brief and overall lacked the level of detail to reflect people's likes, dislikes, and preferences in a person-centred way. One example was a care plan relating to continence needs that was clinical and did not record the impact of continence issues on the person.

One individual's needs around personal care only contained basic information about what they needed support with but not how they preferred to have that support provided. This care plan stated that the person needed full support to wash, bath and clean teeth and stated that the person was 'fully dependent'. There was no information about, for example, what toiletries the person liked, how long the person liked to stay in the bath or how they had their hair washed and without this level of detail to guide staff who may carry out tasks differently, people may not receive consistent care and support. It also stated in the care plan that the person was able to wash intimate areas if prompted, which differs from the information to staff that the person was fully dependent for their care needs. The use of a label such as 'fully dependent' may not guide staff to promote and encourage the person's independence where possible.

However, we saw one care plan with a 'client profile' that contained detailed information about the person's

preferences around their daily routine.

We observed that staff did not always include people in decisions about things they liked to do. One person was watching a 12 rated film in a lounge area during our tour of the houses. However, staff were told to turn of the film by a senior manager who immediately on entering the room told them firmly, "This film is not appropriate, turn it off." We saw another person in distress that was told firmly, "[Person] stop it. You will go to your room in a minute to listen to relaxing music." Staff did not explore why they were distressed and appeared frustrated with the person.

One person received additional funding for one-to-one hours; staff were not able to demonstrate that these were used to offer additional meaningful engagement and activity. We saw that in one of the houses the member of staff allocated for one-to-one was sitting in a communal lounge watching two people, one of whom was meant to be receiving the additional input.

One member of staff was observed sitting with a person and colouring in silence. The person was not involved in this activity and the staff member did not speak or engage them in the activity. Managers told us that this was because the person found it difficult to engage, the staff were spending time with the person unobtrusively and this meant the person occasionally joined in when they felt they wanted to.

We observed handovers that referred to tasks, rather than the person, their presentation or their well-being. Whilst people did enjoy time spent away from their home at the day centre and in other activities, those left in the two houses received task focused interventions rather than meaningful and engaging activity.

We observed that people at the service did have the ability to communicate and express their opinions, either verbally or through expressions and behaviours. Whilst some people at the service would benefit from set plans due to the nature of their autism, we did not see how the plans had been decided on and how the different preferences of people had been considered.

This was a breach in Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Person centred care.

People took the same yearly holiday and not every person would be able to go as some people found the change of routine difficult. Managers told us that people liked to return to the same place. They told us it was difficult to obtain the funding needed for smaller holidays, but when people had their own funds or family members who wished to participate then this was made possible. The provider told us that they used the holiday time to carry our redecorating and essential maintenance to ensure minimal disruption to people living at the service.

Relatives we spoke with told us that they knew how to make complaints and would phone the service and speak to the registered manager or other member of the management team. One relative told us that they had raised a number of concerns and that the service made promises that things would change and be put into place. However, they told us, "They have fits and starts. They seem to initially do something and then it just stops." The were no records of complaints at the time we visited the service.

The registered manager told us that any complaints would be discussed with the senior management team, at staff meetings and during one to one handovers. However, as supervisions and staff meetings did not always take place and the feedback received from relatives was not always positive, we could not be confident that the service used complaints to make improvements.

Four people had been living at the service since childhood when the service provided was as a children's home for people with learning disabilities. The home subsequently became a home for adults with learning disabilities, people were now approaching middle age, and we saw that the service had recently opened a new smaller house elsewhere and had moved a person from the service to this house. The senior manager team told us that the person's needs had changed the older they had become and they felt they a smaller home would be better for them. We saw that this had been done sensitively to the person's needs and that the person had been consulted about the move.

Requires Improvement

Is the service well-led?

Our findings

Staff at the service did not receive regular management supervision or observations of their care practices. This meant the registered manager did not have a thorough oversight of staff skills and competencies and consequently could not be certain of the quality of care that people received and the day-to-day culture across the two houses. They had not used information from staff about their training needs to improve the service.

The registered manager and senior management team did not have effective processes in place to ensure that the environment was clean and safe. Maintenance records identifying environment problems had not been actioned, in spite of some being classified as urgent by staff.

Following the inspection, we met with the registered manager who has since put in place weekly maintenance meetings to ensure that maintenance issues logged are actioned without delay.

The provider did not have systems in place to use information collected from audits, staff, incidents, and complaints to improve the service provided. The management team were unable to demonstrate how the service measured the quality of care provided to people against current guidance and best practice. However, we met with managers and management board to discuss concerns and they were responsive to our findings and had put into place measures to improve the service.

We spoke with staff who understood how to report concerns about care practices and how these should be managed. They told us the management team was supportive and that they were able to report concerns without fear of discrimination. Staff told us they were actively encouraged to raise their concerns.

Senior managers spoke passionately about the service and people living there. They told us they held people in the service in high regard and with great affection, especially since many of them had lived there since they were young adults. However, our observations were that people were not treated as adults and were treated in a manner that did not reflect their age or maturity. Treating people with learning disabilities as though they were children does not reflect good practice, in particular, we had concerns about how people were treated when they presented with behaviours that challenged the service. Insufficient importance was placed on seeking people's views and involving them in their care. We saw incidents where decisions were made for people without any consultation.

Appropriate safeguarding alerts were not made to the local authority when people at the service had become aggressive towards each other. In addition, the provider had not submitted notifications of these incidents to the Care Quality Commission. The registered manager had not considered the emotional impact of assault, even when people had not been physically injured. Consequently, the service had not monitored the emotional impact of repetitive assaults and how this may have affected a person's behaviour and wellbeing within the environment.

There was little choice for people, and staff did not have the skills to understand how to support people who

faced challenges when trying to communicate their needs and views. For example, knowing how to identify unmet needs, people's individual preferences and how to offer and ascertain choice. Where staff had informed managers during supervisions that they required additional training in communication skills, this had not been provided to all staff.

We were provided with a survey analysis about the quality of care provided to people at the service. Only one person in Cedar House had been surveyed and it was documented that the remaining nine people would not be able to take part. The service had not documented how they had assessed the quality of care provided to this group thorough other methods, such as observations from external professionals, advocacy, or other forms of communication that staff might use. Relatives had been consulted for their views and were mostly pleased with the service, although when they had expressed they were concerned we did not see how the service was using this information to improve these concerns

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Good governance.

Managers did however make themselves accessible to staff out of hours and in emergencies. Staff were able to contact the general manager directly to raise any concerns. The number was displayed throughout the houses, managers told us relatives and people at the service could use it. An on call system was also in place so that staff knew who to contact for advice and support out of hours. This included a second manager on call in case staff were unable to reach the primary on call manger.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not complete notifications to the Care Quality Commission about incidents affecting the safety of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People at the service did not receive care that was person centred and individualised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect by some staff who needed additional training in communication and supporting people with behaviours that challenged.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff had a poor understanding of mental capacity and consent. Staff did not consider peoples capacity, did not complete capacity assessments in line with the code of practice which included the involvement of people or others in making best interest decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not taken appropriate measures to ensure the safety of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had failed to ensure that the premises and equipment had been safely maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to use information learnt from incidents, complaints and staff feedback to improve the quality of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service did not ensure that staff had the skills to effectively care for and manager the needs of people who presented with needs that challenge.