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Bedrock Lodge

Inspection report

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Date of inspection visit:
27 September 2016
28 September 2016
29 September 2016

Date of publication:
24 November 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bedrock Lodge provides accommodation and personal care for up to 11 people aged 18 years and over. At the time of our inspection 11 people were using the service.

This inspection was unannounced and took place on 27, 28 and 29 September 2016.

The grounds of Bedrock Lodge contain a small holding and teaching rooms. This functioned as the day service base for people living at Bedrock Lodge and, two other homes a short distance away, also registered with the provider. We inspected these two other locations at the same time as Bedrock Lodge. Our reports of those inspections should be read in conjunction with this report. In this report we have described the care people received at Bedrock Lodge. This includes people living there but also the care provided to others attending Bedrock Lodge as part of their day care activities. The two other locations registered with the provider are; Bedrock Court and Bedrock Mews. You can read the report of our inspection of each of these locations on our website at www.cqc.org.uk.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager of Bedrock Lodge was also the registered provider.

We identified serious concerns during this inspection. We wrote to the provider outlining the most urgent of these and told them to provide us with a report of actions they would take to address these.

The provider/registered manager and staff had failed to recognise where certain practices compromised people's dignity and respect. We could not be satisfied that promoting dignity and respect was fully understood. We found some of the terminology written in a people's care records was subjective in nature and reflected a personal opinion from staff. The tone of the accounts did not reflect a sense of compassion or sympathy and, evidenced a lack of knowledge and understanding of people's needs. Interactions with people using the service seemed at times abrupt and dismissive. There was a lack of evidence to support that staff were there for the benefit of the people they were supporting. The service was, in many ways, demeaning to people and did not contribute towards them being viewed as valued individuals.

People did not receive a service that was safe. Staff did not have a good understanding of how to recognise the possibility of abuse and report concerns appropriately. Risk assessments had not resulted in sufficiently detailed plans to keep people safe. Staff were not aware of the contents of risk assessments and management plans. There was not enough staff at night to ensure people were safe. Records regarding the administration of medicines were not maintained correctly. Checks had not always been carried out to ensure staff were safe to work with vulnerable people. The building and environment was not always safe from hazards.

The service did not provide effective care and support. Staff had not received the training required to effectively meet people's needs. The registered manager and staff did not have a good understanding of the Mental Capacity Act (MCA) 2005. People were not encouraged to make choices and decisions. The involvement of other health and social care professionals was not sought and, as a consequence people's needs were not always met. People did not have access to hot drinks or snacks when they wanted them.

Staff did not treat people in a caring manner. People's relationships with family and friends were not always supported. People's independence was not promoted. People were expected to conform to the 'house rules'.

The service was not responsive to people's needs. People were required to fit into the service rather than the service being designed and delivered around their needs. There was little or no choice about the type of activity people did during the day or how they wanted to live their life on a daily basis. The service did not encourage people to express their views and opinions and, when they did, action was not always taken.

The service was not well-led. The culture of the service was not empowering and person centred. The service provided was institutional, dictated by routine, with a rigid hierarchy. Quality systems were not operated effectively. People's views were not used to make improvements. The provider/registered manager had not worked positively with other health and social care professionals.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 service was not safe.

Staff did not have a good understanding of how to recognise the possibility of abuse and report concerns appropriately.

Risk assessments had not resulted in sufficiently detailed plans to keep people safe.

There was not enough staff at night to ensure people were safe.

Records regarding the administration of medicines were not maintained correctly.

Checks had not always been carried out to ensure staff were safe to work with vulnerable people.

The building and environment was not always safe from hazards.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training required to effectively meet people's needs.

The provider/registered manager and staff did not have a good understanding of the Mental Capacity Act 2005 (MCA).

People were not encouraged to make choices and decisions.

The involvement of other health and social care professionals was not always sought and, as a consequence people's needs were not effectively met.

People did not have access to hot drinks or snacks when they wanted them.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always treat people in a caring manner.

People were not always treated with dignity and respect.

People's relationships with family and friends were not always supported.

People's independence was not promoted.

People were expected to conform to the 'house rules'.

Is the service responsive?

Inadequate

The service was not responsive.

People were required to fit into the service rather than the service being designed and delivered around their needs.

There was little or no choice about the type of activity people did during the day.

The service did not encourage people to express their views and opinions and, when they did, action was not always taken.

Is the service well-led?

Inadequate

The service was not well-led.

The culture of the service was not empowering and person centred.

Quality systems were not operated effectively. People's views were not used to make improvements.

The provider/registered manager had not worked positively with other health and social care professionals to ensure a high quality person centred service.

Bedrock Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 27, 28 and 29 September 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection was carried out by one adult social care inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of services for people with long term mental health needs. A specialist advisor is a person who has professional experience of this type of service. The specialist advisor was a psychology professional with experience of services for people with learning disabilities, mental health needs and autistic conditions.

The last full inspection of the service was on 29 and 30 January 2015. At that time we found there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were Regulation 11 (Need for consent) and, Regulation 17 (Good governance). The breach of Regulation 11 was as a result of people being at risk of care being given without consent. This was because staff had not received appropriate training and, authorisation had not been sought from the appropriate authorities regarding deprivation of their liberty. The breach of Regulation 17 was as a result of, people being at risk of not being provided with the care they needed because care records were not consistently maintained. We also made a recommendation that the provider reviewed their system for ensuring the views of people using the service and others were sought and acted upon.

Following that inspection the provider sent us an action plan detailing the action they would take to improve these areas in order to comply with this regulation. We then carried out a focussed inspection in July 2015 to check if improvements had been made. As a result of that inspection, we found improvements had been made and rated the service as 'good'.

Prior to this inspection we looked at the information we had about the service. This included information of concern shared with us by health and social care professionals and information from 'whistle-blowers'. We also reviewed the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Due to the number of individual safeguarding concerns raised regarding the providers services. This location (along with two others managed by the provider) was under a process of 'organisational safeguarding'. This is a process initiated by the local authority as a result of the number and/or severity of concerns raised with them. CQC had attended a meeting prior to this inspection. This meant CQC had been closely involved with a number of health and social care professionals, social workers and commissioners regarding the service. We have referred to the intelligence reports we have received from those that visit the service and from multi-agency meetings we have attended.

Our analysis of the information received led us to bring forward our inspection and carry out a comprehensive review of this service.

During the inspection we spoke with seven people that lived at Bedrock Lodge. In addition to this, we spoke with seven people who lived at the two other locations and used the facilities at Bedrock Lodge on a daily basis. The remaining people declined to speak with us. However, we were able to observe their care and support throughout our visits.

We spoke with the provider/registered manager, two office based staff and five care staff.

We looked at the care records of five people living at the service, four staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Despite some positive responses from people around feeling safe, we identified a number of concerns and breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches put people at considerable risk and it was evident people using the service would not always have the understanding to recognise that this was the case and that they were not always safe.

Risk assessments were not always in place to keep people safe. Those assessments that had been developed, lacked detail and guidance for staff to follow in order to reduce or prevent risks from occurring. Assessments did not result in clear care plans on how to manage risks to keep people safe. This was particularly concerning as people had significant health and complex behavioural needs. For example, one person who had epilepsy did not have a risk management plan for staff to keep them safe both within the home and, when out engaging in activities. Other people had needs arising from a range of different behaviours including self-harm, aggression to others and needs regarding moving and handling. These people did not have risk management plans for staff to keep them safe.

The recording of the administration of medicines was not safe. As required ('prn') medicines had been administered with no clear recording or rationale of why. There were no clear records of how people presented before and after the administration of medicines for anxiety and distress. As a result it was not possible to determine if the medicine was required and, if so, whether it had been effective. One person was prescribed emergency medicines for health problems arising from epilepsy. There were no clear guidelines in place for how and when to administer this. Guidance on the administration of these prn medicines was unclear. Staff we spoke with did not know how to find the guidance that was in place.

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

Night time staffing levels at Bedrock Lodge were inadequate. One staff member slept in at the service overnight. They were responsible for the safety of 11 people with a variety of complex needs. People had varying levels of communication and would need assistance to evacuate the building if required. There was also a real risk of confrontation between people when anxious or distressed. When speaking with staff it was clear they had not considered the risks that could arise at night. When asked what they would do if they required assistance, they all said they would ring the provider/registered manager. They were not clear how they would summon further assistance if they were not available. One person using the service questioned whether there was sufficient staff at night. They said, "If I have a problem I will see the night staff, who sleeps in. There's only one on at night. I'm not sure if that's enough".

Staffing levels during the day did not allow for individual care and support. The staffing levels at Bedrock Lodge had not been assessed using a recognised staff dependency tool. Staff said there was not enough staff. Comments included; "I don't think there is enough staff" and, "We could do with more staff. It's difficult to keep an eye on everybody". Throughout our inspection we saw people wandering aimlessly around the grounds with little or no observation or support from staff. On several occasions we saw people startled or

frightened by another person who was clearly agitated and anxious. There were no staff close by to reassure the person.

Four 'apprentices' were employed at the service. These are staff that are supported to achieve a diploma qualification (formerly NVQ). Their contract of employment is usually time-limited and they are paid a reduced wage. They are usually new to the care profession and working as an 'apprentice' often provides a good route into care and, allows the employer to fully assess whether they are suitable for the role. One had been employed on this basis for more than two years. We were told by senior staff that 'apprentices' were supervised by a more experienced staff member when providing care and support. However, people and care staff told us this wasn't the case and that they provided care and support unsupervised. Considering people's diverse and complex needs the apprentices did not have the qualifications, competence, skills or experience for the work they were expected to perform.

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

Checks were not always carried out on staff to ensure they were safe to work with vulnerable people. One care worker who had been in post for more than two years did not have a Disclosure and Barring Service (DBS) check in place or, any references from previous employers. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. Senior staff confirmed this staff member was providing care to people. Whilst these checks were in place for other staff, we were concerned the provider/registered manager had not considered the potential risks and conflict of interest in this instance. This was because the staff member was related to the provider/registered manager. This meant people had been put at risk of receiving care from a person who had not undergone satisfactory checks to ensure they were safe to work with vulnerable people.

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

People were not kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Newly appointed staff had not received training on safeguarding. Staff we spoke with did not have a good understanding of how to report any concerns they had about a person's safety or welfare. Across the providers three locations 13 individual safeguarding referrals had been made between the beginning of May 2016 and the end of August 2016. The majority of these had been raised by third parties. When the provider had made referrals raising concerns about people's safety they had not always been raised in a timely manner. For example, a staff member had raised concerns to the provider regarding staff behaving inappropriately towards one person. This was not reported to the correct authorities until they were raised a second time by the same staff member two weeks later.

Staff did not have the necessary skills to keep people safe. They had received NAPPI (Non-abusive Physical and Psychological Intervention) training. However, they lacked knowledge on how to avoid potential triggers, how to de-escalate people's mood and what they should and should not do with regards to physical interventions. The appropriateness of physical interventions had previously been raised (by a third party) as a safeguarding concern. It was evident that lessons had not been learnt by the provider/manager. For example one person regularly sat on the floor refusing to move both at home and when out. Despite a safeguarding investigation regarding inappropriate physical intervention (when a staff member was alleged to have picked this person up roughly) there were still no guidelines for staff to follow. When asked why the person put themselves on the ground the provider/registered manager had responded at an organisational safeguarding meeting, "Because she can". Staff told us they were concerned about their ability to provide

care for this person. One said, "We don't really know what to do when she's like that".

Following one safeguarding investigation the provider/registered manager had taken action to terminate a staff member's employment. However, they had not immediately made a referral to the DBS to inform of concerns regarding the person's suitability to work in care. This has now been done following the provider/registered manager being directed to do so by the local authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Bedrock Lodge was dank, dark and smelt in certain areas. Furnishings in communal areas looked tired with significant wear and tear. The bathroom on the ground floor was in poor repair. The grouting between the tiles inside the shower area was black and mouldy and the radiator on the wall was rusty. Visiting health and social care professionals commented that, 'the home was 'stark, cold and not a homely place to be'. We saw that the dining room, lounge and upstairs of the home had recently been re-decorated. However, the overall condition of the home did not lend itself to safe and effective management of infection control risks. Staff had not received training on the control and prevention of infection.

Outside the home the surfaces underfoot posed a risk for people. A number of people using the service were unsteady on their feet. Concrete surfaces were uneven and in those places where gravel had been used, people with mobility difficulties were at risk. At the front of the house was a set of steep steps; one step had part of a slab missing. To the left of these steps was a sloping bank leading to a levelled shingle area. When the ground is wet or slippery these could pose a hazard. This had not been identified as a potential hazard to people's safety. As a result no control measures had been put in place to keep people safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We could not be satisfied with the rationale for the locked electric gates leading to the service. These were usually kept shut and signs underlined the need to do so. However, we saw these gates left open for periods of time. Staff were unable to explain why these gates needed to be kept shut. If they are required to keep people safe they need to be shut at all times. If they do not need to be kept shut to keep people safe, their value and use should be reviewed, as they are a restriction on people's freedom and, do not promote people who use the service in a positive light.

Inadequate

Is the service effective?

Our findings

People did not receive a service that was effective in meeting their individual needs.

Staff had received basic training in areas such as; first aid, food hygiene and fire training. However, they had not all received specific training to meet people's individual needs.

For example, several people required assistance with their communication needs. We were told by other professionals that attempts had been made to organise communication workshops for staff. They reported it had not been possible to arrange these with the provider/registered manager. It was clear through observation and staff interactions that people would benefit from staff that had essential skills in verbal and non-verbal communication techniques. A member of the inspection team tried to speak with two people and found it difficult to understand what they were saying. One member of staff told them they wouldn't be able to communicate with them. However, they did not offer any assistance to the person or advice on how to achieve this to the member of the inspection team.

Other people needed support to manage their behaviours. We saw staff had limited skills in helping people when anxious, distressed or angry. Through speaking with staff it was apparent they lacked knowledge in how to do this and, that they were ignorant of any guidance provided in people's care plans.

Some people had specific diagnosis of health care needs, for example epilepsy, moving and handling, depression and anxiety, personality disorder and autism. Staff had not received training to help them provide effective care and support.

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

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found that one person's DoLS authorisation had lapsed. This meant the person was being deprived of their liberty without authorisation. A number of DoLS applications that had been submitted for other people were not authorised and returned by the authority(s) because those people had the capacity to make the decision themselves. A DoLS assessor employed by the local authority had attended a staff

meeting to update staff. They reported, 'staff were hostile, reticent and did not understand DoLS'. It was clear from this and discussions with the provider/registered manager and staff there was no understanding of the principles of the MCA. Staff were unable to explain their responsibilities to support people to make choices and decisions. This was further evidenced by the practice of locking doors, meaning people could not access parts of their home. This included their kitchen, bathrooms and toilet facilities. .

A CCTV system was in place which enabled the office based staff to monitor people's whereabouts both within the home and the grounds. We understood this was put in place as a response to an incident in the past where a staff member had sustained injuries. There had not been any recent consultation with people, or anybody acting on their behalf, to seek their views on this level of surveillance. The provider/registered manager or staff could not see the need to review whether the system was beneficial and proportionate in balancing the safety benefits with people's right to privacy.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

Involvement from relevant health and social care professionals had not always been sought. Only one person from Bedrock Lodge was receiving input from the Community Learning Disabilities team. We saw little involvement from psychology professionals to assist in helping people with, managing their behaviour, speech and language therapists to assist people with their communication needs, or independent advocates to assist people to make choices and decisions.

Health and social care professionals told us they felt the service did not seek their assistance and was sometimes resistant to this. We were told how on occasions professionals who had made appointments found when they visited; the person and/or relevant staff were not available. Service users health action plans did not identify how their assessed needs would be met. For example one person had identified needs around coping with anxiety, depression and lack of self-esteem. The only strategy that had been put in place to support this person's needs was to exercise for 30 minutes a day.

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

People confirmed they did not have access to hot drinks or snacks when they wanted them and they were not happy about this. Kitchen doors were routinely kept locked.

We could not be satisfied that staff supervision was effective because of the concerns we identified at this inspection. Supervisions should support staff to help identify and ensure they have the knowledge, skills, attitudes and behaviours to carry out their roles and responsibilities effectively. Staff members told us they received regular supervision and records confirmed this. Supervision records were brief but did contain details of conversations with staff on how they could improve their performance in providing care and support. Staff gave mixed feedback on whether they found their individual meetings helpful. Three staff said they found them helpful two said they were not. One staff member said, "It's just a tick box exercise, so they can say they've done it".

We recommend the provider seeks advice from a reputable source on staff management.

Inadequate

Is the service caring?

Our findings

The service was not always caring. We had serious concerns about the lack of respect that some staff had shown towards people. One person told us about an incident that happened three months previously, where a member of staff had been 'aggressive' towards them, 'pushed' them and called the person 'a bastard'. They also told us they had found staff had locked themselves in the kitchen and when they requested a cup of tea, they would say "We are not your slaves, go away". Other comments included, "The staff haven't shouted at me. Only the residents", "The staff have shouted at me, not aggressively, but sometimes the door gets shut in my face" and, "They might have shouted at me, but I don't mind. They might have had a bad day. My father used to shout at me. But nobody has hit me here".

Care plans did not provide guidance for staff on how to provide support when people presented with behaviours that could be described as 'challenging'. We asked staff for people's behaviour management plans. We found the plans we were shown did not provide the guidance staff would require to provide care and support when people were upset, anxious or angry. Some had recently been updated as a result of feedback from a recent visit carried out by representatives of the local authority. They had reported that plans contained value-laden judgements about people's abilities, behaviours and physical and mental health conditions, with little or no factual evidence to substantiate this. They reported that one person's care plan, described them as a 'sociopath' and stated they were a 'predator' to young vulnerable people. They said they could not find evidence of any current clinical diagnosis to corroborate this. They further stated that the same person's care plan for 'personal finance management' said, 'He thinks money grows on trees. What he sees is what he wants. He lacks the skills to manage his finances'. These statements, although removed when we inspected, had undermined the person. We looked at this person's financial management plan and saw no plans for supporting them to develop their skills in managing their own money or to increase their knowledge about the value of money.

People were not treated with dignity and respect. People all went to bed, ate and had drinks at the same times. These times were written down as 'house rules'. Five different people told members of the inspection team that they were expected to abide by these rules. Comments included; "We have a curfew at 10pm and if we have a problem at night we can go and knock on the door to see one of the staff. We don't have a call bell in our room" and, "You are encouraged to go to your bedroom by 9pm, you have to be in bed by 10pm, and you can't go out". In care plans we saw written statements such as, 'remind him of house rules'. Mr. Men characters were displayed on people's doors. We saw these were often negative characters like, Mr. Angry and Mr. Nosey. These were childlike and potentially insulting.

One upstairs toilet had a frosted glass door. People could be seen using the toilet through this. Doors to toilets, bathrooms and kitchens were routinely locked. People had to request access. The only toilet unlocked during the day, was outside, at the rear of the building. On day one of our inspection we saw one person use this toilet with the door open. This was either not noticed by staff showing us around, or not seen as a concern, as they did not acknowledge this.

We were concerned about the lack of respect shown to us by one particular staff member who seemed to

fail to understand the significance of our role. Their attitude was flippant and one of ridicule. They initially led one member of the inspection team to believe that they were a' resident' living in the home rather than a staff member. This was in front of people using the service and other staff members. The member of the inspection team commented that this staff member was, "very condescending towards male and female residents' and 'seemed to think what we were doing was a joke'.

Relationships between people and staff were unequal. Staff did not take advantage of the time available to engage with people. We saw staff congregating together rather than spending time talking with people. This was particularly noticeable at lunch time. Language and terminology used by staff when describing people did not always show they respected them. For example, one senior member of staff described a person to us as a 'clever kid'. The person they were referring to was 41 years of age.

Through looking at care records and talking with staff we saw there was little recognition of the importance to people of maintaining contact with families and friends. People were not supported to make new friends. People's independence was not promoted. Care planning, the rigid routines within the service and staff approach to people, all contributed towards dependence being fostered.

Some people showed us their bedrooms and some effort had been made to support people personalise to their rooms. However, this had not extended to the communal areas of the home. The service had the feel of an institution more than a home.

People's movement around their home was restricted and all the doors leading to the bathrooms and toilets were kept locked. Any door that had a lock on it was locked. People had little or no access to the kitchen, everything had to be asked for and everything was controlled by staff. The home had a conservatory that was allocated as a smoking room. On a number of occasions we saw people trying the door handle to go from this room out into the garden and, finding it locked, tutting, cursing or smiling wryly to themselves. One person trying the door said to us, "I don't know why that's locked". There did not seem any reason for this door to be locked. Staff could not explain why it was kept locked. One of the inspection team commented that staff appeared more like prison officers walking around with bunches of keys.

Over the three days of our inspection, everyone received lunch at the same time. Only cold options were available on the days we inspected and, consisted mainly of sandwiches and a salad option. For example, on day one people had a choice of sandwiches or potato salad with tuna.

Staff had not received training on equality and diversity. Staff we spoke with did not have an understanding of their role in ensuring people's equality and diversity needs were met. Care plans did not assess people's needs with regards to equality and diversity. There was no appreciation of people's cultural or religious backgrounds, sexual orientation or any other relevant protected characteristic as defined in the Equality Act 2010.

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

Inadequate

Is the service responsive?

Our findings

People did not receive a service that was responsive to their individual needs. Care and support was not person centred. People were required to fit into the service rather than the service being designed and delivered around their needs.

Care plans were not sufficiently detailed or written in a person centred manner. We asked staff for people's care plans. Those we were provided with did not give a clear picture of people's life history, likes and dislikes or hobbies and interests. This was significant as people clearly wanted to talk about their family, previous employment and other topics of interest to them. Staff showed little knowledge of people's lives. We saw no evidence that people had not been involved in developing or agreeing their care plans.

People's care plans contained a 'key information sheet'. This included lists of clinical conditions people had. Some of these were spelt incorrectly and were not always accurate. For example, one person's list had a number of omissions that were important to the way care and support should be provided. These omissions included; anxiety, depression, epilepsy, paranoia and sensory processing difficulties. Care plans also included information sheets on certain conditions that had been printed from the internet. These had not been accessed from reputable sources. Staff said they did not use these care plans.

Behaviour management plans were in place for a number of people. We asked staff for these plans and discussed them with them. These had been drawn up with little or no involvement from relevant health and social care professionals. Staff were often not familiar with the content of these. They contained lists of behaviours people may exhibit. These were written using judgemental language and phrases, for example; manipulation, property destruction and physical aggression. Suitable measures were not put in place for staff to support people in a sensitive, caring manner when people exhibited these behaviours. The only guidance staff had been given when people's behaviours required intervention included; explain house rules, reward good behaviour and ignore attention seeking. In addition to this guidance being institutional in practice, it reinforced the control staff had over people. This meant the root cause of people's behaviour was not addressed but was often exacerbated.

On day two of our inspection we observed one person who had limited verbal communication and was receiving one to one staff support. The member of staff supporting them said, the person was 'having a bad day'. The person was rushing about and being quite loud which was causing distress to other people in the home. The staff member was trying to stop them hurting themselves and others. Collectively, staff decided to take the person out for a drive in the minibus to calm them down. The person sat in the minibus at 11:36 hrs. At 11:41 hrs they were taken from the minibus for no apparent reason.. At 11:45 hrs they were put back onto the minibus and they were eventually taken out at 12:00. Throughout this 20 minute time of deliberating the person's anxiety continued to escalate because staff were unsure what to do.

When we were able to talk with staff they said they had previously tried to have the person sectioned under the Mental Health Act. They said this was because they feared they would hurt themselves or someone else. We were told they had put their hand through a double glazed window and had to go into hospital. Around

the same time they had hurt their head by banging it against the glass window. Another staff member told us this person used some Makaton. Makaton is a communication system that uses signs and symbols to help people to support spoken language. This was not used and staff had not received training in this.

There was a physical intervention file in place. Entries recorded the actual incident that had occurred but did not record the use of any physical interventions. This meant it would not be possible to review the effectiveness of any strategies in place for people.

Care plans contained some 'essential lifestyle plans'. The idea behind essential lifestyle plans is that they place the person at the centre of the design and delivery of their care and support. However, people, their family and friends and other health and social care professionals had little involvement in developing these. Where goals had been set for people, they were not involved and the goal was not aspirational but 'more of the same'. Examples of goals were to; 'Stay at Bedrock Lodge' and, 'Continue to attend day care'.

Two people told us of individual activities they took part in. One person attended a local church on their own, and another person went to local college for classes. However, from talking with other people and, looking at daily records we found there appeared to be little or no choice about the type of activity most people did during the day. They either attended 'day care' at Bedrock Lodge or planned community activity en-masse. There were no external providers of activities or services coming into the service. Holidays were taken in large groups of nine to twelve people with four to five staff.

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

The complaints file held at Bedrock Lodge contained a record of complaints that had been received during 2016. One complaint had been made regarding Bedrock Lodge. This did not clearly identify how this had been managed or, how feedback had been provided to the complainant. This complaint had been received in April 2016 from a family member stating they had not been invited to a review meeting. There was no record of a response to them.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The arrangements in place to ensure the service was well led were unsatisfactory. The provider/registered manager struggled with the management of the whole service and there was an inconsistency in approach. This compromised essential aspects of service provision. Evidence of breaches in regulations throughout the inspection demonstrated that there had been serious failures to identify and manage risks for people across the service. Lack of strategies and forward thinking meant risks were not minimised. This was particularly around providing prompt access to suitable training to equip staff with the right skills to provide safe, good quality care.

The provider/registered manager did not always have people's best interests at the heart of their service. They had been resistant when offered support, guidance and advice from community, health and social care professionals. It was evident that they were reactive to improving the service they provided rather than being proactive. There was a lack of insight and vision as to how they intended to improve the service. Systems for monitoring the quality of care were not robust enough and had failed to identify the serious failings of the service.

Throughout our inspection we found the atmosphere at the service to be institutional and led by routine. The culture of the service was not empowering and person centred. The provider/registered manager and staff lacked understanding and passion in, providing high quality person centred care.

The experience of people using the service was of a closed environment. They lived at the service, used the day care facilities at the service and activities and holidays took place mainly in groups. This raised the risk of people becoming further isolated from their family and friends and the wider community. This had not been recognised as a risk factor. Measures had not been taken to reduce this risk and help people to learn and develop. The overall impression of the service was that it was deskilling people rather than promoting their independence, value and self-worth.

The provider/registered manager had not taken advantages of opportunities to keep themselves up to date with best practice or develop partnerships with key organisations. Feedback from health and social care professionals consistently spoke about the feeling they were 'kept at arms-length' from the service. In fact some felt, the provider/registered manager was resistant to any advice given and portrayed an attitude of 'knowing what was best for people'. This was concerning, as the varied and often complex needs of people using the service meant it was important for them to receive input from a range of professionals. This would also help staff to develop their knowledge, confidence and abilities in providing care and support to people that was effective, respectful and meaningful.

The provider sent out annual surveys to obtain the views of people using the service, relatives and other professionals. The provider/registered manager said the surveys that had been returned in 2016 were currently being collated and analysed by one of the assistant managers.

Some quality checks on standards within the service had been carried out. There were checks on

management of medicines, health and safety, staff training and supervision. However, these were not planned in a systematic way and had not resulted in identifying any shortfalls in these areas. Care plan audits had not been completed. Accidents, incidents and complaints were not audited. This meant any themes or trends were not identified or any action taken to keep to keep people safe or improve the quality of service they received.

The provider/registered manager and senior staff knew when notification forms had to be submitted to CQC. These notifications informed CQC of events happening in the service. There was a lack of confidence from other professionals that safeguarding information was consistently reported in a timely manner.

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

The provider/registered manager acted as financial appointee for most people. This was documented in people's care plans. However, there were some mistakes with this. For example, one person's plan was incorrect in stating the provider/registered manager was appointee when a family member had this responsibility. An office based member of staff kept financial records of income and expenditure for each person. These were comprehensive. However, the provider/registered manager failed to follow best practice by ensuring arrangements were transparent and had not arranged for any independent audit of these records.

We recommend the provider/registered manager reviews the systems for supporting people to access and manage their finances.

Staff were not always clear regarding their roles and the lines of accountability. When faced with any emergency situations staff were not clear what to do, in order to respond promptly. This particularly applied to two occasions where staff should have contacted emergency services for medical assistance but rang the provider/registered manager before doing so. There was no formal on call system in place for staff. They told us the provider/registered manager lived close and could be contacted at any time. There were not clear what they would do if they were not available.

We recommend the provider/registered manager reviews the systems in place to ensure staff are able to take the correct action in emergency situations.

The provider had not published ratings on their website as required by CQC.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care because, their needs and preferences were not assessed comprehensively, with the involvement of the person and appropriate others. 9 (3) (a). Care was not comprehensively planned to meet their needs. 9 (3) (b). Health and social care professionals with the required knowledge and expertise had not been involved in designing, delivering and reviewing their care. 9 (3) (c).

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. 10 (1). People's autonomy, independence and involvement in the community was not promoted. 10 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care was provided in accordance with the requirements of the Mental Capacity Act 2005 (MCA). 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm because risks had not always been assessed. 12 (2) (a). People were not protected from harm because action had not been taken to mitigate against risks. 12 (2) (b). People were not protected from harm because the premises were not always safe. 12 (2) (d). People were not protected from the risks associated with medicines. 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured staff had been kept up to date to enable them to identify and report concerns regarding people's safety. 13 (2). People were not safeguarded from abuse or improper treatment because staff were unclear regarding the use of physical interventions. 13 (4) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not operated an effective system for receiving, recording and responding to complaints from service users and others. 16 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had not assessed, monitored and planned to improve the quality and safety of the service provided. 17 (2) (a).

The provider had not assessed, monitored and mitigated the risks relating to the health and safety of service users. 17 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured staff employed were of good character prior to appoint. 19 (1) (a). The provider had not ensured all staff providing care had the qualifications, skills and experience for the work they were required to do. 19 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not ensured their website signposted the most recent rating by the Commission of their performance. 20A (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff to keep people safe. 18 (1). Staff had not received the training required to meet people's individual needs. 18 (2) (a).