Ashstone House Limited

Ashstone House

Inspection report

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Date of inspection visit:
06 June 2016
07 June 2016

Date of publication:
27 July 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on the 6 and 7 June 2016 and was unannounced. Ashstone House provides accommodation and support for up to 12 people who may have a learning disability. At the time of the inspection 10 people were living at the service. All people had access to communal lounge areas, a dining area, kitchen, shared bathrooms and a large well maintained garden. Ashstone House was last inspected on 09 January 2014 where no concerns had been identified.

The Care Quality Commission requires a registered manager be 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 had been de-registered from the service in April 2016. The provider had appointed a manager to manage the service; they had taken up post on 09 May 2016. They had submitted an application to register with the Care Quality Commission (CQC) at the time of our inspection. The new manager was present throughout the inspection.

People were not protected from abuse. Safeguarding incidents had not been reported following the provider's own policy or to meet the safeguarding legal requirements of the local authority.

There were enough staff to meet people's immediate needs but staff numbers were not always sufficient to be flexible to the needs of people leaving the service to pursue outside interests.

Safety checks had not identified the risks of a fire door being propped open or the lapsed fire alarm checks. Emergency evacuation plans had not been reviewed for six years and some were not in place where needed. The provider had not done everything reasonably practical to reduce the risk of harm to people.

People were put at risk of receiving their medicine inappropriately because staff did not have up to date and clear information to refer to.

The provider had failed to comply with the requirements of the Mental Capacity Act 2005. The provider had not notified the Commission when standard Deprivation of Liberty Safeguards (DoLS) authorisations had been made; this is a requirement of the Commission's registration regulations.

Although formal supervision of staff had lapsed staff said they felt supported and able to approach the new manager if they needed help and guidance. The new manager had identified this is an area which needed to improve.

Training records were insufficient to demonstrate the provider was providing staff with the necessary training to support people with their individual needs. However, staff could demonstrate they had the necessary skills and knowledge to support people safely. Staff benefited from a thorough induction process

to prepare them for their role.

Although people knew how to complain and raise concerns the complaints procedure was not displayed and could not be located within the service.

Some documentation was out of date and had not been reviewed for a long period of time. This meant people were at risk of receiving inappropriate care and support. This was recognised by the new manager who had started to make improvements to some of the documentation.

Although maintenance planning processes were in place, the pace of repair did not always keep up with the rate of wear. Shortfalls in the maintenance of the service did not promote a well maintained environment.

The culture of the service was not wholly person centred and some of the language and behaviour staff displayed did not promote dignity and respect towards people.

Staff were positive about the direction of the service and the appointment of the new manager.

Safeguarding incidents had not been identified or reported following the agreed processes. Areas of practice which placed people at risk had not been acted on to improve.

People had choice around their food and drinks and staff encouraged them to make their own decisions and choices.

Staff demonstrated caring attitudes and were patient and respectful when communicating with people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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?

Requires Improvement

The service was not consistently safe.

People were not protected from abuse. Safeguarding incidents had not been reported when needed.

People were at risk of receiving their medicine inappropriately.

There were enough staff to meet people's immediate needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The Mental Capacity Act 2005 had not been fully complied with. The Commission had not been notified by the provider when authorisations to deprive people of their liberty had been granted.

Staff benefited from a thorough induction process.

People were involved in making decisions about their food and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some behaviour that staff displayed and language used in reports was not respectful or dignified.

Staff respected people's privacy and encouraged them to make their own choices.

Staff had sociable and engaging interactions with people and demonstrated they cared about their welfare.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were inconsistent, out of date and some lacked

enough detail to inform staff how they should consistently respond to people's individual needs.

Some people were not always able to do the activities they wanted to do at specific times due to the number of staff deployed.

People could make complaints about the service they received which were responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Internal systems had been unsuccessful in identifying areas the provider needed to respond to, to protect people.

Documentation was conflicting and required updating to reflect the current needs of people.

The new manager had started to make changes to improve the service.

Ashstone House

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 the 6 and 7 June 2016 and was unannounced. The inspection was conducted by two inspectors on the first day and one inspector on the second. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. The provider had been asked to complete a Provider Information Return (PIR) prior to the inspection but was unable to complete this because it had been sent to the previous registered manager. A PIR is used to help us inform our Key Lines of Enquiry (KLOE) for inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We collected this information during the inspection.

During the inspection we spoke with 10 people, six staff members, the new manager, and the area manager. After the inspection we received feedback from one relative. Not all people were able to express their views clearly due to their limited verbal communication so we observed interactions between staff and people. We looked at a variety of documents including five peoples support plans, risk assessments, activity plans, daily records of care and support, incident reports, four staff recruitment files, training records, medicine administration records, and quality assurance information.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and content. One person said, "I'm happy and safe, I don't have any worries living here". Another person commented, "I feel safe, I don't worry about anything". However, we identified some areas of practice which meant the service was not safe.

People were not protected from abuse. Safeguarding incidents had not been reported following the provider's own policy or to meet the safeguarding legal requirements of the local authority. Incidents of alleged abuse should be reported to the local authority or The Commission for investigation. For example, in April 2016 a person was allegedly hit by another person in the stomach and in May 2016 a person was slapped on their legs by another person. The incident form stated this was 'messing around' but there was no mention in the persons care plan to say this was part of their usual behaviour. Local authority protocols categorise slapping and hitting as abuse. Another incident recorded a person was head butted by another person as they walked past. The new manager and staff explained the person had thrown their head backwards as the other person was walking behind them. A further two incidents in May 2016 involved people being exposed to physical harm. However, records lacked detail to understand incidents and action taken by the service to safeguard people. We raised this as a concern with the new manager who acknowledged and had identified recording and reporting of incidents was not robust enough and needed to improve.

Safeguarding and whistle blowing information was available for staff to refer to, and staff did have a good understanding about the process to raise concerns about people's safety. However, a lack of management oversight had meant incidents had gone unreported and un-investigated. The new manager said, "It's about being transparent and reporting what we need to. It's about getting the care plan right and knowing when to report as an adult protection incident. Staff need to be guided more". Incident forms were collected over a period of a month before being passed to the new manager for review; this demonstrated poor management as the new manager did not have an up to date oversight of incidents occurring.

The provider did not have an effective system in place to ensure incidents of abuse were reported and investigated. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of receiving their medicine inappropriately because staff did not have up to date and clear information to refer to. For example, a document stated 'on a one to one basis the service users must be supported to the office to take their meds'. This was not what happened in practice and staff took people's medicines to them. Another document stated a person would verbally request their occasional use medicine (PRN) when they were in a pain. However, a staff member said this person would not ask for the medicine so it was unclear how the person would receive it if they required it. Another person's PRN guidance stated 'if person is showing any signs of challenging behaviour, staff must contact the manager and medicine given'. There was no description of what specific 'challenging behaviour' would warrant the need of PRN which meant this could potentially be given at inappropriate times. Clear guidance was not available for staff to follow to be certain PRN medicine was administered consistently.

One person was prescribed a medicine which had strict protocols around administering and, if administered incorrectly, the medicine could be ineffective. One requirement was it should be given at 8am and half an hour before other medicines, however medicine administration records (MAR) showed this medicine had been given with the other prescribed medicine at 9am. We raised this as a concern with the new manager, who told us staff did administer this medicine separately, but recordings of this were unclear, staff also confirmed this to be the case.

Temperatures to ensure safe storage of medicines were not recorded and a thermometer was not available for staff to take readings from. Non refrigerated medicines need to be stored at temperatures not exceeding 25°C, this is because storage above this temperature risks medicines becoming desensitised, not working as intended or potentially ineffective. For the same reasons, refrigerated medication should be stored at temperatures between 2°C and 8°C. Staff said that they had identified they should be recording temperatures and were waiting for a new thermometer to be sent from the pharmacy. There were no body maps or other documentation to instruct staff where people required their prescribed creams or how they should be applied; some people were unable to communicate this to staff. During the inspection a body map was implemented to improve shortfalls in this area. Other areas of medicine practice were safe; medicines were administered by a team leader and witnessed by a trained staff member to reduce the risk of mistakes and medicines were all accounted for when checked.

Door Guards were fitted to each fire door and checks took place to ensure they operated correctly; however, one person's door was propped open with a piece of furniture and therefore would not close automatically if the fire alarm sounded. Weekly fire alarm checks had taken place up until 22 April 2016, but had then lapsed without explanation. Some people may need help and assistance to leave the service in the event of an emergency evacuation. Individual personal emergency evacuation plans (PEEPS) should establish people's support needs and how they may respond to an emergency situation; staff should be aware of these support needs. Discussion with the new manager found they had identified the need to review existing PEEPS, because they had been completed in 2010, and additionally PEEPS were not in place for three people. This potentially placed people at risk because existing plans had not been reviewed against current needs and PEEPS were not in place for each person.

The provider had failed to have proper and safe management of medicines; Safety checks had not identified the risks of a fire door being propped open or the lapsed fire alarm checks. Emergency evacuation plans had not been reviewed for six years and some were not in place where needed. The provider had not ensured that risks were suitably assessed or mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing should comprise of five staff on the day shift as well as the new manager, five staff on the afternoon/evening shift and two waking staff to provide support at night. Although staffing allocations ensured a senior team leader was always on duty on each shift; staff rotas from 11 May to 10 June 2016 showed a number of shifts where staffing had been reduced to only three or four staff per shift. This did not meet requirement the service had assessed it needed and impacted on people receiving allocated one to one hours and being able to leave the service to pursue outside interests and activities.

On the second day of the inspection outings were restricted due to the availability of drivers. A relative said, "My relative doesn't seem to be getting out much, I think this is due to staffing". Other staff undertook duties such as housekeeping. A cook provided meals and the service employed a part time coordinator to organise activities two days per week. Agency staff were occasionally used to cover staff shortfalls which could not be met through the use of existing staff. Where possible the service used the same agency staff to help to ensure consistency of care. People were not benefiting from staffing, which was flexible to their preferences,

but were dependent on the availability of staff.

Sufficient staff were not deployed to meet the needs of people when required. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff undertook duties such as housekeeping. A cook provided meals and the provider employed a part time coordinator to organise activities two days per week. Agency staff were occasionally used to cover staff shortfalls which could not be met through the use of existing staff. Where possible the manager used the same agency staff to help to ensure consistency of care.

Disclosure and Barring Service (DBS) checks had not been undertaken for one person working at the service. DBS checks are required for unsupervised staff aged 16 and above who have direct access to, or work directly with adults at risk. This is to establish if any cautions or convictions mean that an applicant is not suitable to work at a service. In addition, as part of recruitment processes, the manager must obtain two references for applicants; in the case of the same member of staff, although requested, no references were present. The area manager and new manager were unable to confirm that the references had been received or the DBS had been requested. The area manager contacted the companies' human resources department but remained unable to confirm the checks had been received. Other recruitment files viewed contained the required information to ensure staff were suitable for their roles.

Processes were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. This is a breach Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was free from odour and clean. Most areas of the service, including people's bedrooms were well decorated and some new floor coverings fitted. However, the service's maintenance planner identified in January and February 2016 painting of walls and woodwork was required for the stairs, hall and landings. This had not happened. Dried water stains were also evident on the dining room ceiling and small areas of paint were peeling from the laundry room walls, in addition there was a small hole in the laundry room ceiling caused during the repair of a water leak. Although maintenance planning processes were in place, the pace of repair did not always keep up with the rate of wear. Shortfalls in the maintenance of the service did not promote a well maintained environment. Where dates for required work had passed, these had not been rescheduled. We have identified this as an area requiring improvement.

Environmental safety audits highlighted any hazards or repairs needed throughout the service and records confirmed these had been completed promptly. For example, the floor structure in a lounge was identified as sagging and replaced with new carpeting fitted, two new boilers had been installed and maintenance of the service's private drainage facility had been undertaken. Other records showed equipment checks regularly took place to help keep people safe, these included gas safety, electrical installation, portable electrical appliances, fire fighting equipment and hot water temperatures. People had their own individual risk assessments according to their needs. Risk assessments gave a description of the area of risk, who was at risk, and the level of risk. There was a description of what staff could do to minimise the risk and what action should be taken to achieve this.

Requires Improvement

Is the service effective?

Our findings

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 make 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Capacity assessments and best interest decisions had not been made when people lacked capacity to make simple decisions. Two people were currently subject to a DoLS authorisation and another person's had lapsed but no renewal of this application had been made. The provider was unaware the authorisation had lapsed. The new manager and area manager said they had identified this as an area which needed to be revisited and improved. Because the correct processes had not been followed, people were being deprived of their liberty in an unlawful way.

The provider had failed to comply with the requirements of the Mental Capacity Act 2005. This is a breach of Regulation 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member said, "I haven't had a formal supervision for a while but the new manager is approachable and I can talk to them at any time". Another staff member commented, "The manager asks me how I am and if I need help, the manager is supportive to me. The other staff help and advise me". Supervision of staff had lapsed for some staff in the current year; nine staff had not received any supervision and no annual appraisals had taken place for any staff in the previous year. Supervision and appraisal processes are intended to enable managers to maintain oversight and understand the performance of all staff. Supervision is used to ensure competence is maintained, as well as providing a formal forum for discussions about best practice, setting of personal objectives and development plans for staff. This helps to ensure clear communication and expectations between managers and staff. Where needed, supervision provides a link to disciplinary procedures to address any areas of poor practice, performance or attendance. The services policy detailed that supervision should take place every other month and an appraisal annually. The new manager had been in post for a short period of time and although a supervision schedule was in place the new manager was yet to act on it. The new manager said they had spent time getting to know the staff and people at the service which was one of their main priorities. The new manager explained how they had spoken to, and corrected a staff members practice after observing them deal with a persona behaviour which was challenging to others.

The provider was unable to provide us with clear information during the inspection of training staff had received. We asked the provider to send us information after the inspection to show how they were meeting this requirement. The information received indicated a large percentage of staff had not completed the essential training to undertake their roles. Only 26.32% of staff had completed emergency first aid, 30% had completed challenging behaviour and breakaway techniques, 20% had completed diabetes training,

73.68% had completed fire marshal training and 40% had completed mental capacity training. The new manager explained the information provided was not a true reflection of the current percentage of staff who had completed each course as they were waiting for certificates to be sent. Although areas of staff training had lapsed staff were able to demonstrate they knew how to support people safely.

Staff employed by the service provider must receive appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The failure to ensure staff received sufficient training and support is a breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

A staff member said, "When I began work I shadowed for three days and was slowly given more responsibilities when my confidence improved". Induction training for new staff had previously been based on common induction standards for staff working with people with learning disabilities. Common induction standards were competency based and in line with the recognised government training standards (Skills for Care). The new manager had enrolled all new staff to undertake the training for the new Care Certificate. This is an identified set of standards that social care workers adhere to in their daily working life. Other training for new staff included some class room based sessions, shadowing experienced staff, written assessment workbooks and observational assessments of competency. This helped to ensure staff had understood what they had been taught and could apply their training in practice. Induction could be extended or staff could be asked to repeat units if necessary. This helped to ensure staff had the right basic level of knowledge and skills to support people effectively and safely. Discussion with staff confirmed they understood their roles and responsibilities.

Although staff were able to describe what action they would take improvement to documentation was required to maintain people's safety. One person's guidance around their epilepsy did not give enough information to staff to follow in an emergency. Although their seizure activity had been well controlled for a number of years, guidance did not specify how staff should respond in an emergency situation if the person had a seizure and required further medical help. The guidelines did not give details of how staff would recognise if the person was having any seizure activity and gave no time scales of when further medical help should be sought. Referrals were made to specialist health professionals when required. A person had been referred to the speech and language therapist (SALT) when they were identified as having problems eating. Staff followed the guidance that SALT had made to support the person at meal times.

People told us they liked the food, one person said, "I had spaghetti on toast for lunch and I am having curry later. I like shepherd's pie". Two options for meals were offered to people on a daily basis, the cook used picture cards to help people to understand the choices available. One person needed food prepared in a specific way to minimise the risk of them choking, staff were aware of this and food was prepared to a softened consistency in a presentable and appetising way. Another person was diabetic and the cook described how alterations were made to ingredients to accommodate this. A choice of cold drinks were left out for people which they could help themselves to at any time and hot drinks were offered to people frequently. The cook said, "A person came back from an outing and said they had seen steak and they would like it. I went and bought it for the person and we cooked it together". The cook kept a log of meals people enjoyed and tracked if there were particular meals people had gone off. This was particularly useful if people were unable to verbally communicate their preferences.

Requires Improvement

Is the service caring?

Our findings

One person told us, "I feel very happy here, they have all been very kind to me". Another person commented, "All of the staff are kind, I feel well Supported". Staff were respectful of people's right to privacy and encouraged them to make their own decisions. This was demonstrated when a person received a letter and a staff member asked them if they would like to open it themselves. The person requested the staff member should do this for them. The staff member asked the person if they would like them to read them their letter and waited for their response before proceeding. Although there were aspects of the service which were caring, we identified areas which required improvement.

The culture of the service did not always promote peoples dignity and respect. A relative said, "I didn't like the way a staff member spoke to a person once when their behaviour was difficult. I felt it was unnecessary". The new manager said, "I think some of the practice here is not person centred. I feel some of the behaviour and language used by staff could be improved". An example of this was a person's incident record which stated they had behaved in a particular way because they were 'looking for attention'. Rather than being more specific about what had caused the incident the report responded with generalisations. The new manager said they had to re-educate staff about how they interacted with people when their behaviour was difficult to manage. One staff had told a person, "You will get an ABC for that (this refers to a form which is used to record incidents of behaviour which has challenged others)".

People had not always been treated with dignity and respect. Regulation 10 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

Staff enjoyed their work and were proud of the support they provided. A staff member commented, "I like it here, I like looking after people. We give people choice which is important as it's their life". Staff were responsive to people's requests to communicate with them and were reassuring if people became anxious or distressed. For example, when one person asked where their laundry was, staff went with the person to show them where it was and offered verbal reassurance to help the person manage their anxiety around this. When a person came to the office and asked the new manager when they were able to go to particular places of interests, the new manager spoke to the person in a caring and patient way, allowing them to express their wishes before responding.

We observed people and staff throughout dinner. Staff communicated with people throughout this time and responded to requests. For example, one person asked for ketchup to go with their meal which staff provided immediately. People were offered various options of drinks and when one person complained their food was not very hot, this was immediately dealt with so they were happy.

People were relaxed and happy and were able to freely move around all areas of the service. They socialised and engaged with one another and staff in an informal and relaxed way. During the inspection people sat in the grounds with each other and staff and chatted sociably. Staff showed concern for people's welfare and offered people sun lotion to protect their skin as it was a sunny day.

People's rooms were decorated in a way personal to them with various personal objects and pictures that were important for people to have around them. The service had commissioned photographs of each person, which they had framed and placed in people's respective bedrooms.

People were provided with information and support to make contact with advocacy services if they should need this. One person had been allocated an advocate to support them when a DoLS authorisation had been requested. People's involvement and consent had been sought when writing their care plans. In one person care file it stated, 'I (staff member) have discussed the support plan with the person but they do not wish to sign it'. Another person care file had been signed by the person to say they had been involved in writing it.

Requires Improvement

Is the service responsive?

Our findings

People felt their activities reflected their interests and staff listened to what they said. One person said "I asked about moving to a more independent environment and that's happening soon. So yes, they do listen to what you say". Another person commented, "I like it here. I like to go out with (staff member) to buy clothes. I usually go shopping on a Tuesday". Although people were happy with the support received, some shortfalls meant the service was not always responsive.

Staff did not have clear guidelines about people's current needs or how to support them in the best possible way. The new manager said, "The care plans have some good documents but other things need updating. When you look at them you will see they don't always cross refer. It's something I picked up on; it will be part of our plan to improve". Some documentation in people's care files had not been reviewed for a long period of time and was not up to date with their current needs. For example, two people had physical aggression/intervention documents to direct staff in how to manage situations which could become physically challenging. One person's guidelines had not been reviewed since 28 September 2013 and the other person's had not been reviewed since 13 August 2014. Both made references to a particular intervention strategy which we were told by the area manager was no longer used by staff. One person's care plan stated they used Makaton to sign. Makaton is a language programme using signs and symbols to help people to communicate. Staff did not use Makaton to communicate with people and had not been trained in using it. Although records needed to be updated to reflect peoples current needs staff were able to demonstrate a good understanding of the people they supported. Staff communicated with people in their preferred way and recognised when they were anxious or needed extra support. Some people had complex needs and staff described how support would be delivered in a personalised way. This is an area we have identified as requiring improvement.

Other parts of the care plans were personalised for individuals and included photographs of them throughout. Information included what the person liked and did not like, their dreams, what they liked to do when they went out or stayed in the service, how they should be supported to access the community, a consent agreement to the support plan, and guidance for other areas of the person's daily life. One person had watched a football match in London in 2012. They spoke to the manager about attending another football match and visiting London in the future which the new manager said they would discuss and plan together with their key worker.

We spoke with people about their activities. One person said, "I like living here, I like painting in the garden and making teapots for Christmas. We have Christmas parties. I like my roses and my garden, there's a lot going on here. Tomorrow I will go out with (staff) to buy some more roses". An outside area of the garden had been laid out as football pitch with small goal posts. People were enjoying a game with staff throughout both days of the inspection. Two people had gone on a weekend trip to play football the previous month which was of particular interest to them. During the inspection some people visited the day centre and some went for a drive and a walk. Within the grounds two people had their own designated garden area and sheds. One person's garden area and shed had been moved closer to the service due to their decreased mobility. People had their own personal belongings stored in their sheds and they could come and go as

they pleased. People told us they enjoyed to look after the flower beds, water the plants and window boxes. One person stored a set of golf clubs in their shed which they had recently purchased at a boot fair. They said they were planning on learning how to play and during the inspection they hit some golf balls with some of the other people who lived at the service. Although people did have access to activities away from the service, this was dependent on the availability of staff and drivers on shift.

People told us they did not have any complaints and did not wish to make any. One person said, "I would speak to staff if I was worried and they would sort it. I'm not worried about anything". People told us they knew the staff, the new manager and provider by name and were confident that, if given cause to complain, it would be resolved quickly. One person told us how staff had supported them to make suggestions to the local council about improvements they thought could be made to the community. However, services are required to have a complaints procedure for people and any visitors to the service; it should be in an accessible format for people who may wish to use it. We spoke with the new and area manager who confirmed although once in place, the complaints procedure was not displayed and could not be located within the service.

Requires Improvement

Is the service well-led?

Our findings

A staff member said, "The new manager has been asking for our ideas and suggestions on how to improve the service, they have been involving us a lot more". Some of the practice's staff had adopted had not been wholly person centred. The new manager said some practices had been imbedded for a long time and the attitudes and behaviours of staff would take time to change. The new manager said, "It's the culture I need to change with staff, I need to get the team leaders on board to change how staff think and behave. There's so much potential here, but there's a lot to change. Things have been done in the same way".

Some documentation was out of date and had not been reviewed for a long period of time. This was recognised by the new manager who had started to make improvements to some of the documentation. The new manager said, "Documentation needs to be updated and person centred, there's not enough to demonstrate that things are person centred, there is limited pictorial signage for people. Some of the daily logs don't pick up what the antecedent, behaviour, consequence (ABC) records say". Recorded documentation confirmed this to be the case. There had been an incident where a person dragged another person. An ABC record had been made but the persons daily report record made no reference to the incident. The lack of current information meant people were at risk of receiving support that did not meet their current needs, or support would be provided in an inconsistent way by staff. In the absence of up to date guidance, new staff would be reliant on other staff to inform and guide their practice.

The new manager said, "I spoke to some of the staff when I came and they haven't always been shown how to do things or haven't had the right guidance. There's a lot of paperwork to catch up on". People's guidance to help them manage behaviours which could challenge others was outdated and did not contain the most up to date information to inform staff of how to respond to incidents. People could display behaviours which were verbally and physically challenging towards others. One person's care plan said 'if person is becoming agitated and distressed suggest that they go to their room to relax. They may take themselves to their room or may continue to remain where they are. Do not get into a situation of 'nagging' or pushing them to go.' Several incident reports said the person was asked to go to their room for a "time out". This was not following the stated guidance. The provider stated that restraint was not used to manage people's behaviour although guidance in peoples care files indicated it was used as a last resort. Information was conflicting and did not promote consistent and effective management of behaviours.

Records were incomplete, conflicting and had not been kept up to date. The provider had not ensured suitable systems identified, monitored and addressed shortfalls requiring improvement. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a service receives a decision from local authorities in response to an application made under Deprivation of Liberty Safeguards. This is where restrictions are needed to help keep people safe in the service. Statutory notifications informing us about three decisions had not been made to The Commission. Numerous incidents had gone unreported and people left at risk of repeating incidents.

The registered person had not notified The Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The culture of the service was not wholly person centred. People were not always treated in a way which promoted their freedom and choice. An example of this was when a person had been refused a biscuit because it was not the assigned time for biscuits to be given to people. This resulted in the person having an incident of verbal aggression towards staff. The new manager had picked up on this incident and had instructed staff to cease to place restrictions on people which could be a trigger for behavioural outbursts. The new manager was working towards making changes to the culture of the service which they recognised would be a challenge as changing a culture of a service can be a long process.

Internal audits had been planned and conducted by the provider to identify areas which required to improve in the service. The provider had made some improvements in areas which included systems for managing people's money and had identified that care plans needing updating where there were information gaps or guidance was out of date. The new manager said, "Apart from the internal audits there are no recorded plans in place yet to improve the service. I am making my own now and finding out the priorities". The most recent internal audit had been conducted in April 2016; the provider had not identified that recording and management of medicines, staff recruitment files and training records were in need of improvement. When areas had been identified as needing to improve reports lacked information about the action taken and follow ups made.

The provider also conducted quarterly health and safety inspections to assess if the premises were safe. Quality assurance surveys were sent to care managers, GP's, the learning disabilities community team, families, staff and people in June 2015. Responses had been received and analysed, and action had been taken if needed. All responses received had been positive. One person had commented that they wanted to become more independent with managing their money which they had been supported to do.

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 had not notified the Commission of events which they had a statutory obligation to do so. Regulation 18 4(A)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People had not always been treated with dignity and respect. Regulation 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to comply with the requirements of the Mental Capacity Act 2005. Regulation 11(1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to have proper and safe management of medicines. Safety checks had not identified the risks of a fire door being propped open or the lapsed fire alarm checks. Emergency evacuation plans had not been reviewed for six years and some were not in place where needed. The provider had not ensured that risks were suitably assessed or

mitigated. Regulation 12 (1)(2)(a)(b)(d)(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 did not have an effective system in place to ensure incidents of abuse were reported and investigated. Regulation 13(1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were incomplete, conflicting and had not been kept up to date. The provider had not ensured suitable systems identified, monitored and addressed shortfalls requiring improvement. Regulation 17(1)(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Processes did not promote the principles of a robust recruitment process to protect the safety of people living at the service. Regulation 19 (1)(a)(2)(a).

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 suitably qualified, competent, skilled and experienced staff to fully meet people's needs. Staff employed by the service provider must receive appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(1)(2)(a).