Enigma Care Limited

Little Acorns

Inspection report

Little Acorns
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 26 February, 3, 11, 15 and 16 March 2015. The first four of our inspection visits were unannounced. We informed senior staff that we would visit on the 16 March as the primary purpose of the visit was to pick up photocopies of documents we had requested to be made available. The inspection was carried out in response to concerns we had received about the service and was carried out by two inspectors. We also met with the provider, the acting manager and deputy manager on 18 March 2015 to discuss the findings of our inspection and the actions we proposed to take.

On 20 August 2014, we carried out an inspection of the home under the HSCA 2008. This was a follow up inspection to check whether outstanding compliance actions from an inspection in April 2014 relating to care and welfare, quality monitoring and consent had been met. During the August 2014 inspection we found that none of the outstanding compliance actions had been met and in addition there were new breaches in regulations regarding supporting workers and co-operating with other providers. We asked the provider to take action to make improvements and this action has not been completed.

Summary of findings

Little Acorns is registered to provide accommodation with personal care for up to 11 people who have autism. Little Acorns is also registered to provide a personal care service to people who live in their own homes in the community. At the time of this inspection there were nine people living permanently in Little Acorns and there were also three people who regularly stayed there for shorter periods of respite care. Three people shared a house in Winkleigh who received a personal care service, with a fourth person staying regularly for respite care each week. One older person who lived in their own home received personal care visits from care staff five times a day.

The provider is also the registered manager of the service. Since our last inspection of the service on 20 August 2014 the registered manager had ceased to provide day to day management of the service. An acting manager had been appointed but at the time of this inspection no application to deregister the registered manager or to register the acting manager had been received by the Commission. Therefore the provider remained legally responsible as the registered manager for the day to day management of the service. 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.

Concerns found during this inspection were so great that the service is subject to a multi-agency safeguarding process. As part of that process, a multi-agency safeguarding protection plan was agreed with the provider, CQC, police and health and social care professionals to protect people's safety and well-being. This included health professionals visiting the home regularly as part of the support plan and in a protection role.

People were not safe. There were insufficient staff to meet people's needs. Staffing levels during weekdays were inadequate, and some people, who had been assessed as needing one to one support from staff, were left without support for significant periods during the day while staff were busy with other tasks. Staffing levels at weekends were often dangerously low, leaving people with insufficient support from staff. When we began this inspection there were no waking staff on duty at Little Acorns at night and support for people was provided by two sleeping-in staff. This meant people who woke during the night did not have staff readily on hand to give them the support they needed.

Staff recruitment records did not provide sufficient evidence to show new staff were recruited safely. New staff did not always receive a full induction before they were expected to work on their own. This meant people with complex needs were often supported by new or inexperienced staff who did not have the expertise, knowledge or training to understand their needs.

Staff did not receive regular supervision or support. Some staff said they had asked for supervision and guidance but this had not been given. Communication was poor. Some staff described divisions among the staff team and a lack of teamwork. They said there was a culture of bullying by the management team and concerns raised with them had not been listened to or addressed. Other staff said they were happy working at Little Acorns and had confidence in the management team. There was a high staff turnover.

People had not been involved in drawing up or reviewing their care plan. New care planning documents had recently been put in place for most people but we found these did not fully explain all aspects of people's care needs. One person who received personal care had a care plan that had been drawn up in 2009 by their previous care provider. It had not been reviewed or updated and much of the information in it was no longer correct. This meant staff did not have the information they needed to understand how people wanted to be supported, or how to ensure people's safety and welfare needs were met.

People were not fully consulted about the choice of meals. Staff did not have sufficient information about the foods people could eat safely, or about their likes and dislikes. The quality of food was sometimes poor.

Serious incidents were not reported to the local authority safeguarding team, the Care Quality Commission or to professionals who had responsibility for commissioning people's care. This meant external professionals were unaware of the extent of issues or concerns, and there had been no external overview or scrutiny to ensure serious incidents were investigated or actions taken to prevent recurrence.

Summary of findings

Staff demonstrated kindness and compassion but lacked specialist skills and training needed to understand and support people with autism. A lack of clear and consistent guidance from managers on current good practice often resulted in staff acting in an uncaring way. This was because staff imposed rules and restrictions without recognising people's right to make their own decisions and choices about their lives. Staff failed to recognise people's human rights and failed to seek people's consent before providing care or treatment. At times this resulted in people becoming agitated or angry.

People were not been consulted or involved in the management or daily life of the home. Rules had been imposed without consulting the people who lived there. For example, there were rules about where people could eat or drink in the home, which they did not agree with. People's views on the quality of the service had not been sought, and there were no systems in place to seek the views of other people involved in the service, for example relatives, or other professionals.

Staff did not have the skills or knowledge needed to meet people's needs safely. For example, some people were able to communicate using sign language but no staff had received training on the use of sign language. Although the level of training had increased in the last year, some of the training had been of poor quality. Approximately half of the staff team had completed each training topic.

Risks were not managed safely. Risks had not been fully assessed and staff had not received sufficient guidance on how to support people to minimise risks where possible.

Medicines were not managed safely. Staff had not received adequate training on safe administration of medicines. People had not been consulted, or their needs assessed, to ensure each person's individual medication needs were fully met. Some medicines supplied on an 'as required' basis such as pain relief or medication to control anxiety were stored in the administration office and staff did not have access to these at all times.

The home did not have robust systems in place to ensure people's cash or savings were managed safely. This meant people were at risk of financial abuse.

People's capacity to make choices and decisions about important matters relating to their care and treatment had not been assessed. Four applications had been made to the Deprivation of Liberty Safeguards (DoLS) team to restrict people's liberty. However, we found restrictions and restraints were in place for many other people where no DoLS applications had been made.

We found the service was not well-led. There were inadequate systems in place to monitor the quality of the service. The provider had failed to make sure daily management tasks were carried out effectively and regularly monitored. Concerns, complaints and requests for information raised by staff and relatives had not always been listened to, investigated or addressed satisfactorily. Records were poorly managed and were not always held securely to maintain confidentiality. There were no systems in place to learn from incidents or accidents. Practice was not questioned, and guidance from external professionals was not actively sought where problems or issues were identified.

During the inspection, we identified a number of serious concerns about the care, safety and welfare of people who received care from the provider. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People continued to be at risk of harm because the provider's actions did not sufficiently address the on-going failings. This was despite the significant amount of support provided by the multi-agency team to address those failings. There has been on-going evidence of inability of the provider to sustain full compliance since November 2013. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with any confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations.

In October 2015 we served notices to cancel the registration of the provider and the registered manager with CQC. Enigma Care Limited informed us that they had stopped providing regulated activities on 26 October 2015.

Since the original inspection on 28 February 2015, health and social care professionals have been involved as

Summary of findings

commissioners, or in their safeguarding role, to ensure people's safety and welfare was monitored. During this time, they arranged for people who were using this service to move to alternative provision.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People did not receive the support they needed because staffing levels were inadequate. Staff recruitment and disciplinary methods were not always robust.

People were at risk of accident, injury or abuse because there were poor systems in place to keep them safe. Risks had not been effectively assessed or reviewed. When staff raised concerns these were not listened to, investigated or acted upon.

Medicines were generally stored and administered safely. However, staff were poorly trained and the systems for auditing stock levels were inadequate. People did not have access to medicines supplied on an 'as required' basis when senior staff were not on duty.

People's money was not handled securely and this meant people were at risk of financial abuse. Systems to protect people from the risk of abuse or neglect were inadequate.

Is the service effective?

Inadequate

The service was not effective. Staff did not have sufficient skills or knowledge to meet people's needs. Staff did not receive the supervision or support they needed to ensure people's needs were met. Communication was poor.

People's capacity to make choices and decisions about their lives had not been assessed. Rules and restrictions had been imposed without considering the need to apply for Deprivation of Liberty Safeguards (DoLS) or to seek best interest agreements with other people involved in their care such as relatives, health and social care professionals.

People were not fully consulted about the foods they wanted to eat. Staff did not have sufficient information about people's dietary needs, likes and dislikes.

People's health needs were not met fully.

Is the service caring?

Inadequate

The service was not always caring. Although most staff demonstrated kindness and compassion, they lacked specialist skills and training needed to understand and support people with autism. Some staff also acted in an uncaring way by imposing rules and restrictions without recognising people's right to make decisions and choices about their lives. Staff failed to recognise people's human rights and failed to seek people's consent before providing care or treatment. At times this resulted in people becoming agitated or angry.

Is the service responsive?

Inadequate

The service was not responsive. People were not involved in drawing up or agreeing their plan of care. Care plans did not fully explain people's support needs.

There were no systems in place to actively seek people's views, or to listen, investigate and act on concerns or complaints.

Summary of findings

People did not always receive support to follow their own choice of activities or interests. Facilities such as a swimming pool and music room were not used effectively. Instead, there was a heavy emphasis on people carrying out chores both inside the home and in the grounds or going out for several local walks each day.

Is the service well-led?

Inadequate

The service was not well led. Systems to monitor daily management were poor. The quality of the service was not assessed, and actions were not put in place to make improvements where needed.

There were no systems in place to learn from incidents or accidents. Practice was not questioned, and guidance from external professionals was not actively sought where problems or issues were identified.

People were not involved or consulted in the daily management or routines in the home. Some staff told us there was a culture of bullying by the management team.

Little Acorns

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 26 February and 3 and 11, 15 and 16 March 2015. The first four inspection visits were unannounced. The visit on 16 March was announced.

The inspection was carried out by two inspectors. Before the inspection we looked at the information we had received on the service since the last inspection. We had received no notifications of incidents or accidents.

During our inspection we met each of the nine people who lived at little Acorns. We also visited four people who received a personal care service who lived in their own homes in Winkleigh. We spoke with those who had agreed to talk to us. We observed staff interacting with people during our visits including those people who were unable to communicate verbally. We spoke with three relatives, 21 staff, and reviewed the records of care for six people who lived at Little Acorns and two people who received a personal care service. We spoke with 11 heath and social care professionals. We also contacted the local doctors' surgery.

The areas we looked at during our inspection included a tour of the buildings at Little Acorns. We looked at medicines stored and administered by Little Acorns, we checked to see how three people were supported to manage their money. We looked at records relating to the supervision and training of staff. We looked at the recruitment records of seven staff employed since our last inspection.

At the time of this inspection 29 staff were employed.

Inadequate

Is the service safe?

Our findings

People were at risk of harm or unsafe care because there were insufficient staff to meet their assessed needs. The provider did not have systems in place to determine safe staffing levels and ensure each person's individual needs were met at all times.

Before this inspection took place we received an anonymous concern that the home was constantly understaffed, with insufficient staff to provide one to one support. During our inspection we found the concern we received had been correct and people were not receiving adequate support from staff to meet their needs or keep them safe. There were no waking night staff and staffing levels during the day often fell below safe levels.

Of the nine people who lived permanently at Little Acorns, seven people had been assessed as needing (and had been funded to receive) one to one support from staff during their waking day. Some of these people had also been assessed as requiring two staff on occasions when they went out into the community. Two other people had been assessed as needing one to one support for shorter periods each day. In addition there were three people who regularly stayed at Little Acorns on respite care, usually for one night during the weekend each and over some weekends. We were told people were often left on their own, or one staff was expected to support several people at the same time.

There were no catering or domestic staff and therefore support staff were expected to carry out a range of duties such as cooking, cleaning, animal care, shopping and escorting people to medical appointments, in addition to their support role. Because there were two alpacas, two goats, a pony and some poultry, the animal care required was significant. This meant staff sometimes had to insist people helped them with tasks people did not enjoy, such as feeding, watering and mucking out the animals. A member of staff said "(a person) thinks it's a punishment to look after the animals. (The person) will look after the animals, but it would not be his choice." Alternatively staff said they carried out these tasks without people's assistance, which left people without staff support for long periods.

During our inspection we found staffing levels at Little Acorns were unsafe at all times of the day and night, particularly at weekends. Staff rotas showed that at times there had been only four or five staff on duty on Saturdays and Sundays to support between eight and eleven people, depending on whether some people were visiting relatives. On the first day of our inspection the staff rotas showed there were ten staff on duty. One person had reported in sick which meant there were nine staff plus a senior member of staff working (who was not on the rota) to provide care. Two senior staff assured us that staffing levels were adequate to meet people's needs. However, we saw some people who were supposed to receive one to one support were left unsupported for varying lengths of time. Staff were supporting two or more people even though assessments showed they needed one-to-one support.

During the third day of inspection a person became angry and threw a hot drink over a member of staff. To calm the person down a member of staff took them out for a long walk along with another person who lived there. Both people had been assessed as needing one to one support. No risk assessment had been carried out to consider the safety of the staff or the two people before they went for the walk. We understood this was a regular occurrence. We raised our concern about this with a senior member of staff, who said they were unaware that the second person had gone on the walk. However when we visited the home subsequently, we found that the same two people were out for a walk with just one member of staff. This meant there was a risk of further incidents occurring when the two people were outside of the home, and the staff member being unable to obtain additional support promptly.

One person said they did not feel they received enough support from the staff. They said they wanted to move to somewhere they could receive more attention from staff.

Six staff raised concerns about low staffing levels, particularly at weekends and at night. Comments included "Weekends are desperate at the moment. We are short staffed. We keep complaining but it falls on deaf ears."

We asked a senior member of staff how staff deployment was managed to ensure staff supported people effectively. For example, we asked how they made sure staff carried out tasks such as cooking, shopping or animal care without leaving people unsupported. They said they had recently decided there should always be a senior worker on duty each weekend to oversee and monitor the staff. However, the rota indicated that where the senior staff were working over a weekend, they were undertaking a care worker's role supporting people.

Inadequate

Is the service safe?

On the fourth day of inspection, which was on a Sunday, the rota indicated that one of the senior staff was working in a care worker role. However when we arrived, they were not on site, although they arrived on site about 20 minutes after our arrival.

Three people regularly woke during the night and required support from staff to keep themselves and other people in the home safe. Records showed that one person woke before 6am on 24 occasions in January 2015, and it was often recorded that they were distressed and banging on the locked door between the bedrooms and the main part of the house. However there were only four incident logs recorded in January 2015 about this person being awake during the night and being distressed. This showed that this person's level of distress was being under reported and staffing levels had not taken into consideration the frequency of this person waking and needing support during the night.

An incident log in February 2015 described how the person was supported by a member of staff and taken to the day centre to avoid waking others in the house. We discussed this with a senior member of staff in terms of safety procedures as we had concerns given that there were only two sleeping-in staff on duty at night. The senior staff was unable to explain how the risk to the staff if the person's anger had escalated had been assessed or what measures had been put in place to protect the staff or other people in the home from harm.

People were supported by staff who were working very long hours and were tired. Staff rotas showed some staff often worked very long shifts. For example some staff worked 14 hours during the day (from 8am until 10pm), then carried out a sleeping in shift (from 10pm until 8am) followed by another 14 hour shift the following day. This was confirmed by a member of staff who said they found the shifts long and tiring. Another member of staff said "Staff are over-tired and terribly unhappy."

After our inspection we met with the provider (who was also the registered manager) and two senior staff on 18 March 2015 to discuss the concerns we found during our inspection. They provided copies of staff rotas showing that they planned to provide at least 11 staff each day plus two senior staff. This provided one-to-one support for those people assessed as needing it, plus additional staff to cover staff breaks, or carry out tasks such as cooking. The new rotas showed staffing levels were being increased day and night across the week. They said vacant shifts would initially be covered by agency staff until new staff had been recruited and received full induction training. Two waking staff each night had been put in place.

There were five people who received a personal care service. These included three people who permanently shared a supported living house called The Elms which was owned by the provider. This was located in the centre of Winkleigh. One other person stayed at The Elms for respite care on a regular basis for some nights each week. Staff rotas showed the people at the Elms were usually supported by two staff during weekdays and one staff at weekends. At night the rota showed one member of staff slept on the premises. We saw details of incidents that occurred when people were unsupported in the community. Commissioners told us one person required support from one member of staff three times a day. This meant staffing levels did not fully meet people's needs, particularly when there was only one member of staff on duty.

One older person who lived in their own house in Winkleigh received a domiciliary care service five times a day. We were satisfied their care needs were fully met at the time of this inspection.

We found that the registered person had not protected people against risks to their health, safety and welfare due to lack of sufficient numbers of suitably qualified, skilled and experienced staff. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at increased risk because there was insufficient evidence to show staff were suitable to work with vulnerable people. Staff recruitment procedures were not always robust. Four records contained incomplete evidence of checks and references, for example one record contained no evidence of any references received and the Disclosure and Barring Service (DBS) check had been completed after the staff member had started working in the home. Three other records of staff recruited in the previous twelve months contained evidence showing at least two satisfactory references and a satisfactory DBS check was made before these staff began working in the home.

Inadequate

Is the service safe?

This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered person had not protected people against the risk of financial abuse.

One person's financial records had not been completed since January 2015, although there was evidence that £200 or £300 had been withdrawn from their account every couple of weeks and a number of receipts showed items had been purchased since the last entry. However the receipts had not been logged and it was not possible to identify how this person's money had been spent. This meant the person was at significant risk of financial abuse.

A relative of another person said they had repeatedly requested information about how their family member's money had been spent. When they eventually received information about how much money had been spent, they said it was not clear what the money had been spent on.

We contacted the local authority who agreed to carry out further checks on three people whose money was held and managed by the home on their behalf. These checks revealed that there were concerns regarding at least two people's finances.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person's records were in good order. Receipts had been retained and running balances kept. The balance in the person's wallet was correct. We were told the person's parents held responsibility for the finances and kept a close oversight of their spending.

The registered person had not protected people against the risk of inappropriate or unsafe care. People's needs and risks had not been fully assessed or translated into care plans to address their needs and risks. Risk assessments did not accurately describe the risks for an individual or what staff needed to do to reduce the risk for individuals. Risk assessments and care plans had not been completed for people in relation to significant health issues, such as epilepsy. For example, although in one person's care record there was information about what to do if they had a seizure, there was no evidence about the frequency, likelihood, impact or triggers for such an event. There were no behaviour support plans (BSP) to support staff in understanding how to work with people to minimise the risk of issues occurring.

Although there were some risk assessments for people in their care records, most of these were generic, rather than individual. For example there was a risk assessment in each care record entitled "Working in the Stables". This described risks such as drowning, noise pollution and weather, but not how these risks might be particular issues for the individual.

Information in some risk assessments referred to the wrong person. Where there were risk assessments associated with a particular person's needs or risks, the plan to address the concerns did not describe how risks could be reduced.

All the care plans contained generic risk assessments which were not individualised to suit each person. For example every person had the same choking risk assessment whether they had been assessed as being at risk or not. The initial degree of risk was identified as 'High Risk' for everyone. The first risk of choking stated that 'There is a very real and high risk of choking and death' (but not when or why this might be occur) The other risk identified was 'Risk of staff being prosecuted under 'Manslaughter Charges' should service user die during their care.' The action plan to reduce the risk contained the following instructions: 1:1 staffing, never leaving the person's side. [Person] must be supervised at all times, staff to have prior choking training. The residual risk was evaluated as Low. However, there was no evidence of an individual care plan for most people around choking. These instructions did not provide staff with sufficient detail to be able to support the person concerned, for example what food might be a risk or how food should be prepared.

People were provided with drinks during the day and those that required 1-1 support were encouraged to drink. During the second day we observed one person who was at risk of choking being fed grapes, which had been cut up and offered one at a time, to reduce the risk of choking. However we found evidence that on other occasions they had been given more than one blueberry and these had not been squashed – this had been pointed out by a visiting speech and language therapist (known as SALT). Staff had since ensured that they only gave one squashed

blueberry at a time. When the issue was raised with a senior member of staff, they said that it was in the care plan and also on a notice in the kitchen. A member of staff was able to describe the foods the person was able to eat, and those that were unsafe. We asked if they had seen written guidance from the SALT team but they said they thought it was probably in the care plan but they did not have time to sit and read the care plans. This meant the person could still be at risk of choking because staff had not read important guidance on preparing foods and ensuring people ate them safely.

Another member of staff said they did not feel the meals were of good quality or suitable for people who may be at risk of choking. They gave an example of cheap quick frying steak recently purchased. When cooked it was 'like leather', and people could not eat it.

Risk assessments had not been carried out on any of the three kitchens to enable people with disabilities to use the kitchens safely. Knives had been locked in kitchen drawers to prevent the risk of cuts. However, safety risks relating to boiling water or hot ovens and hobs had been reduced by preventing access to the kitchens instead of considering ways of reducing the risks.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not protected people against the risk of unsafe management and administration of medicines. Most medicines were locked securely in a medicine cabinet in a staff office. The home used a monitored dosage system of medicine administration. Medicines were provided in four-weekly blister pack supplied by a pharmacy. However, medicines prescribed on an 'as required' basis such as pain relief or medicines to reduce anxiety, were locked in a cupboard in the administration office. At times, this was locked which meant staff did not have access to these medicines when people needed them.

There were no clear guidelines for staff to explain when 'as required' medicines should be offered to people. This meant people were at risk of not receiving some medicines when they needed them. We also found that medicines that should be kept cool were stored in the main refrigerator in the kitchen and were not kept securely.

Checks on stock levels of medicines not supplied in the blister packs were not carried out. The records did not show the amounts of medicines remaining at the end of each four week period had been checked. There was no 'brought forward' system to record the amounts carried forward to the following four week period.

Staff had signed the medicines administration records each time they had administered these medicines and there were no unexplained gaps.

Two staff said they were concerned about the level of training provided to staff on the safe administration of medicines. They said there had been medication errors and omissions in the past which they had raised these with the staff concerned. They said they had been concerned because the staff had been unaware of safe practices and the risks to people from medication errors. They said medication training had been provided through computer based courses and this had been poor. They also said they were concerned that no action had been taken to investigate the medication errors or consider actions that should be taken to prevent recurrence.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a senior member of staff on the first day of our inspection to discuss the areas of concern relating to medicine storage and administration. On the third day of our inspection the senior staff member said a pharmacist had visited the home and agreed to provide new storage systems to enable people to hold their own medicines securely in their bedrooms. A secure medicines refrigerator would also be supplied to the home. The pharmacist had agreed to provide training for all staff on safe medicine administration. They also advised on safe recording and auditing procedures and senior staff member said these would be followed in future.

We did not look at the medicine storage and administration for three people who lived in a shared house and received a personal care service. We were assured by a senior

Inadequate

Is the service safe?

member of staff that improvements planned for the people in residential care would also benefit the people who received a personal care service. We looked at the medicine administration procedures for one person who received a domiciliary care service and found their medicines were administered safely.

We found that the registered person had not protected people against the risk of unsafe premises. On the first day of inspection, some internal doors were locked using key coded locks. We were concerned this may prevent safe evacuation of the home in the event of a fire and so we contacted the fire authority for advice. They confirmed that locks on internal doors should be opened easily in the event of a fire. Locks such as key coded locks should be linked to the fire alarm system and disabled if the fire alarm sounded. The locks used at Little Acorns had not been linked to the fire alarms and could not be opened quickly by people who did not know the code or who were unable to operate the locks. This meant people were at risk of being unable to escape from the building quickly in the event of a fire.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the first day of inspection, the lock between the bedroom area and the other parts of the house was removed. Other locks including one on a kitchen door were also removed, although no risk assessment of this was undertaken before the removal. Subsequently a senior member of staff said a risk assessment had been carried out and the lock had been reinstated.

Inadequate

Is the service effective?

Our findings

We found that the registered person had not protected people against the risks associated with staff who have not received appropriate support, training, professional development, supervision and appraisal. During our inspection on 20 August 2014 we found records of staff supervision were not fully maintained, with some staff not receiving regular supervision.

During this inspection we checked to see what action had been taken and found that records of supervision were still poorly maintained. Staff said they did not always receive the support or supervision they needed to carry out their jobs effectively.

A senior staff member said they had responsibility for supervising staff and aimed to provide supervision to each member of staff every three months. A staff supervision file contained brief notes of some supervision sessions since the last inspection. The records showed 18 staff had received at least one supervision in the last six months. There were 12 staff who had received no recorded supervision since the records began. The senior staff member said they was aware some staff had not received regular supervision and said that supervision had been a lower priority than getting care plans up to date. One care worker said they had not received supervision in the previous six years, despite repeated requests for supervision. Another member of staff said they had received one supervision three months previously and a third said they had received two supervisions in the previous four months.

Staff said communication was poor. Comments included "I have no communication at all with the manager", "It's all going to pot. There is a lack of communication," and "There is no communication." A member of staff described an incident involving a person who lived there and told us none of the staff were told about the incident and therefore were unable to support the person effectively.

The registered person had not protected people against the risks associated with staff who have not received training as necessary to enable them to carry out the duties they are employed to perform.

Staff said training had increased in the last year since the acting manager was appointed. They said that until then they had received little or no training. The staff training matrix showed the training topics provided in the previous year included autism awareness, breakaway, challenging behaviour, first aid, infection control, Mental Capacity Act, safeguarding, moving and handling, fire safety and basic food hygiene. Attendance figures showed less than half the staff employed had received recent training in most of these topics, although some staff had completed training several years previously. The training matrix did not provide any evidence of training on safe handling of medicines.

The training matrix showed less than 50% of staff employed at the home had received training relevant to people with complex learning disability or autism needs. Staff had not received training on communication skills (for example, sign language or Makaton), or health related topics such as choking or epilepsy. We saw evidence of incidents where people had been physically restrained, but staff had not received up to date training on safe restraint practice, or how to prevent the need for restraint.

Some staff said the quality of training provided was poor, especially the online computer courses. They were concerned that computer training had not always been completed by staff for various reasons, including difficulty gaining access to the courses from home computers.

Although individual staff records contained some certificates of training completed, many certificates were missing. Senior staff were not able to explain why some certificates were not available in staff files. This meant the number of staff who had received training on the topics shown on the training matrix could not be verified.

The acting manager said they were aware some of the training had been poor quality and they were in the process of arranging training with a new training company.

The training records showed 13 of 29 staff held a relevant qualification such as a National Vocational Qualification (NVQ) level 2 or level 3. After the inspection the provider informed us that 16 staff had attained NVQ levels 2, 3, and 4 and a further 12 staff were working towards a level 2 or level 3 qualification.

We received concerns that new staff were not properly inducted and found evidence that this concern was correct. One member of staff said new staff were often expected to work on their own with people without any period of induction.

Inadequate

Is the service effective?

Staff employment files did not consistently contain evidence of induction training that met with national good practice guidelines. Staff who had been recruited in the last year said they had spent one or two days reading policies and procedures and one week 'shadowing' experienced members of staff before working on their own with people. However, one member of staff was working alone with a person on their first day of employment. There was one completed induction training record which met national good practice guidance but other files either contained no induction training record or incomplete records.

The registered person had not protected people against the risk of unsuitable or unfit staff continuing to work in the service. There was evidence of incidents which indicated poor practice by staff. Senior staff described poor practice relating to some staff. These incidents and concerns had not been investigated, and disciplinary proceedings had not been carried out. There was no evidence to show senior staff had considered any actions to address poor practice. For example there were no records of meetings with the members of staff involved in the incidents to show how their poor practice had been questioned or addressed. The members of staff had not been monitored, and had not received regular supervision. This meant that disciplinary procedures were not robust.

We discussed disciplinary proceedings with two senior members of staff. They said when they had previously considered carrying out disciplinary proceedings the provider had disagreed with their proposed action and this resulted in no action being taken. We expressed concern that they were unable to show how poor practice had been investigated or acted upon. Following this discussion a senior member of staff said they had decided to suspend two staff pending further investigations. There were no clear procedures in place to explain how disciplinary procedures would be carried out. They also said a further two staff would no longer be working at the home following discussion and agreement with the provider, although the reasons for this decision were not given.

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered person had not protected people against the risk of being deprived of their liberty.

People's capacity to make decisions about important matters relating to their care and treatment had not been assessed. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. A Deprivation of Liberty Safeguards (DoLS) authorisation provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

At our previous inspection of the service on 20 August 2014 we found that people's capacity to make decisions about their needs or their ability to give consent to care had not been fully assessed. Staff had restricted people's freedom to move about the home and to do the things they wanted to do. This had not been done in accordance with the MCA.

During this inspection we found further evidence that people's capacity had not been fully assessed and that there were restrictive practices. We saw evidence of one best interest decision that had been called after a professional heard the staff were restricting the number of cigarettes a person smoked each day. A best interest decision had been agreed to continue to restrict the number of cigarettes each day. However there was evidence of this causing the person increased agitation and distress. After discussion with a senior member of staff, another best interest meeting was arranged to look at this matter once again. We found no evidence to show that staff at Little Acorns had recognised the need to seek best interest decisions for other restrictive practices we found.

People had not been consulted or involved in their care plans, and had not been allowed to make choices and decisions about things that were important to them. For example, no agreement had been reached with people for their medication to be held centrally in the home and for staff to administer their medication. Their capacity to make such decisions had not been assessed. This meant the outstanding compliance action had not been met.

There were no clear procedures in place to ensure that staff understood the principles of the Mental Capacity Act 2005.

Although four Deprivation of Liberty Safeguards (DoLS) applications had been submitted for people whose liberty

Is the service effective?

had been restricted there was evidence of people being restrained or restricted without a request for a DoLS assessment. For example, one person was expected to go to bed at 9 pm because staff were concerned they might otherwise be awake all night. Another person had a listening device in their bedroom. They also had a bell on their door which rang in the staff bedroom if they left the room. This was put in place to allow sleeping in staff to be alerted if the person woke during the night and left their room.

We also found evidence that people were being restricted by the use of key coded locks to prevent them entering or leaving certain parts of the home. No DoLS applications had been submitted to authorise the use of this restraint.

We asked senior staff to explain why other doors were locked. These included locks to some toilets, a kitchen, a laundry room, and various rooms in the day centre area. We asked if risk assessments had been carried out before deciding the doors must be kept locked. A senior worker said they were unaware of any risk assessments and were unsure why some of the doors were locked. During our visit all locks were removed. However, no risk assessment was carried out before removing the locks to ensure all risks were considered and actions taken to eliminate or reduce risks. We later received a complaint from a relative who was concerned about the risk of burns or scalds from a hot kettle or hot oven. Following their complaint a key coded lock was put back on the door to one of the kitchens.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not protected people against the risk of unsafe or unsuitable premises. The building had not been designed to meet the specific needs of people who lived there. For example a kitchen in the day centre area of the home did not have worktops, sink or cooking facilities at suitable heights for people with disabilities. The layout was such that there was an opening to access the working part of the kitchen with a heavy hinged worktop which prevented people from entering the area easily when closed. The weight of the worktop presented a risk to staff or people living in the home who needed to lift the worktop to gain access to the kitchen facilities. The gap when the hinged worktop was open was insufficient to allow access for a wheel chair.

A relative said the swimming pool could not be used for many months each year because of the cost of heating the water. They also told us their family member was unable to get out of the pool without assistance due to the lack of handrails.

A large basement room provided a range of facilities such as cinema and musical instruments. However the access to the basement was down a steep staircase which had recessed bolt holes on each step, presenting a trip hazard. This meant people with poor or limited mobility would be unable to access these facilities safely.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found that that people's care and health needs were not met.

On this inspection there was evidence that this regulation was still not being met. Although there was some evidence that some health needs had been considered by staff, people had not been fully consulted about their health needs. Some diagnosed illnesses were not fully explained to staff. Staff did not always recognise the warning signs of potential illness. This meant staff did not have the skills or information to protect people from the risks of ill health.

For example one person's daily records indicated that they had an obsession with showering several times a day for up to two hours, which was a recently manifested behaviour. There was no evidence that monitoring of this behaviour had taken place. There was no risk assessment or behaviour support plan to provide staff with guidance on how to help the person manage this. Although there had been a request to other health professionals for support to deal with this, in the interim, there were no plans on what staff should do.

The registered person had not protected people against the risk of nutritional needs not being met. People were not always able to make choices about their meals and drinks. Meals were not always well planned, or suitable for

Is the service effective?

people's individual dietary needs. The weekly menus were drawn up by staff but there was no evidence to show how people had been consulted. A menu board was displayed in one dining room but we were told this had not been used for a long time. Picture cards intended to help people choose the meals were not used. A member of staff said they had some awareness of each person's likes and dislikes when drawing up the menus. However we saw in one person's notes that they had been given beans on toast on two occasions and had not eaten them. A member of staff had noted after the second occasion that they had remembered the person did not like baked beans.

A menu for the week was displayed in the main kitchen in the Little Acorns area of the building. This was the kitchen used by staff to cook the meals for people in Little Acorns. There was no evidence on the menu of alternatives for people who did not like, or were unable to eat the meals planned.

Some people at Little Acorns were able to help with food preparation and cooking, although care staff did most of these activities. Some people were able to access the kitchen to prepare drinks and one person had a kettle and fridge in their room so they could make a hot drink for themselves.

There were inaccurate records of what people were eating and drinking. For example, one person's daily notes recorded that they refused both lunch and dinner. However in the daily food intake chart, although it was recorded that they had refused lunch, it was recorded they ate dinner, which had not been the case.

There was evidence in one person's daily record that they had been to the doctors for a health review. The notes stated "Need to watch XX's food portion sizes". However there was no evidence that this information had been used to review the person's care plan or that other staff had been informed.

Another person had lost a significant amount of weight. However there was no evidence that this was monitored or that plans had been put in place to identify the causes.

Care notes for another person showed they had been unwell five times over a two week period. An appointment was made with the person's doctor but there was no evidence to show staff had considered the illness may have been linked with the person's eating disorder.

Care records contained a 'hospital passport' for each person. Hospital passports are documents which provide key information about a person which can be taken with them if they have to go to hospital. However, the passports were not fully completed and in some, there were significant gaps and inaccuracies in information. For example in one care record it was identified that the person was in danger of an anaphylactic shock if administered a flu jab. However there was no information about this in their hospital passport. The medicines documented in the hospital passport were different from those in their care records.

Risks relating to health needs had not been fully assessed or reviewed For example in one person's file, there was evidence that they had epilepsy. However, it was only after talking to a care worker, that it was established that the person had last had an epileptic episode over 10 years ago. There was no information about how their condition had been managed in the last 10 years although there was information in the care record which described what to do if the person had a seizure.

Where people's behaviour changed there was no evidence to show that staff had considered this may be due to signs of illness, or that they had identified the potential risks to the person's health. For example, where daily records showed that there were concerns about how much liquid one person was consuming and the amount of time they spent on the toilet, there was no evidence that their risk assessment or care plan had been reviewed or systems put in place to discuss this with health professionals or monitor their intake.

There was information in daily records about people's health needs, but no evidence that this was followed up by staff. For example in one person's daily records during one month there was a comments such as 'itchy testicles, 'complained about feeling faint', 'has sore on face'. However there was no evidence of staff taking any actions to address these issues.

One person frequently urinated themselves but there was no evidence that there was a care plan associated with this behaviour or that this had been raised as a concern by staff with the person's GP.

Inadequate

Is the service effective?

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local GP surgery said they had no significant concerns about the service. One person who received a personal care service had just returned from a medical appointment and said they were supported to receive medical treatment and advice appropriately.

Inadequate

Is the service caring?

Our findings

People told us staff were sometimes "bossy" and told them what to do.

Although we observed staff supporting people in a kind and friendly manner there was also evidence of incidents where staff had not been caring. The lack of written guidance in the care plans on how people wanted to be supported had resulted in staff taking a 'parental' role and placing unnecessary restrictions on people, believing this was in their best interests.

People's privacy and dignity were not fully respected. For example, a member of staff who was supporting a person demonstrated caring and compassion towards the person, but failed to understand the importance of respecting the person's privacy and dignity when they described the person's continence and hygiene habits within the person's hearing.

When people became upset, angry or aggressive, staff did not recognise this may be the result of people's frustrations because they had been subjected to unnecessary restrictions. For example a member of staff described an incident where they heard another member of staff shouting at a person. The incident report, written by the member of staff who had shouted, described the person as 'very demanding'. The member of staff, who had observed the incident, said that when they had arrived "it was like world war three" and also commented that this sort of altercation was commonplace between the person and the member of staff.

In another incident report a person wanted to go out for the evening but a member of staff wanted the person to do their household chores before they went. The person said they were too busy to do their chores. The member of staff also told the person they must be back home before 10pm even though the person said they expected to return by 10.15pm. The person became angry as a result of this.

In a daily report a member of staff wrote "(the person) sadly let herself down", "Pushed a few boundaries but listened well", "did become confrontational", and "took her time completing her chores". This showed staff did not show empathy or understanding towards the person, and failed to understand why the person became confrontational when they were told to do something they did not want to do.

The provider had lots of 'rules' about what people were allowed or not allowed to do. These had not been agreed with people, either on an individual basis or as a group of residents. For example, one person said they had been told that they had to get changed into day wear when they had put their pyjamas on in the early evening. A member of staff had recorded in the person's daily notes that the person had been difficult and confrontational over the issue. This showed the staff had failed to recognise it was the person's right to choose what they wanted to wear.

We discussed the issues of people choosing what to wear and drinking in the lounge with the manager and deputy on the first day of inspection. They said that the issue of wearing pyjamas had been also written in the communication book. The reasons for restricting what this person wore in the lounge which were given by senior staff were no longer relevant and had not been reviewed.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the first day of inspection, a senior member of staff said they planned to make changes and improvements to the way they sought people's views. They held a resident's meeting on 28 February 2015 and minutes of the meeting showed that people were consulted on, and made decisions about, things they had previously been unhappy about. These included an agreement they could take drinks into the lounge in future, they could wear pyjamas around the house from 7pm, and they wanted more choice of meals. They also said they wanted to keep the cats but did not want the alpacas any more.

While being shown around the home we saw staff knocked on doors before entering bedrooms. During our visits to the home we also saw some staff asked people what they wanted to do before helping them (when necessary) to do it.

Inadequate

Is the service responsive?

Our findings

The care plans did not fully describe the care that each person should receive in order to ensure that all their needs and aspirations were met. In some care records there was a description of each person written in the first person; however in others these were not up to date.

We spoke with one person who received a personal care service and showed them their care plan. They said they had not seen the file before and had not been consulted about it. The care plan had been drawn up in 2009 by another care provider when the person lived in a different care setting. The person said the information in the care plan was incorrect and out of date.

Care records did not contain aspirational goals. We talked to one person who was concerned about moving on to supported living, but we saw no evidence that the person had been supported to look at options or find out more about what that might mean.

There was evidence in one care plan that a person had drawn up their own list of likes and dislikes. The daily records for another person stated that they had spent time on one day working on their pen portrait. However, other care plan files contained no evidence to show people had been consulted or been involved in their planning the care they wanted and needed.

There was a strong emphasis on people carrying out 'chores'. Daily records showed people were expected to carry out household tasks such as cleaning and laundry at least once a day and on some days, there was evidence that they carried out chores several times during the day. There was very little evidence in people's care plan files to show how staff had consulted and agreed with them about the level of chores they were expected to carry out, or how these would help the person to work towards gaining greater independence. Where targets had been set for people, the targets were largely focussed on chores, for example laundry and preparing breakfast. Some care records contained sheets entitled 'progress record'. These were dated 1 October 2014. There was evidence that they had been filled in on some days by staff throughout October but there was no evidence of any review at the end of the month or any evidence of the monitoring continuing after the end of October.

There was information in people's care records which provided details about their background, family and preferences. There was also a section entitled "Working with (the person)". However people's care plans did not include information about personal targets or goals.

Some people attended college on several days a week having chosen courses they were interested in. Regular music therapy sessions were held in the conservatory area and attended by some people. One person was sometimes taken to a local farm to collect eggs (although this activity had ceased at the time of this inspection and staff were unsure when it would begin again). One person was supported to go shopping and another went to a conservation group. Each week groups of people went to a club in Crediton, a club in Exeter and a club in Barnstaple. On a monthly basis, some people went to a nightclub in North Devon and the cinema in Okehampton. However, for other people we saw no evidence that they had chosen the activities they participated in, and there was no plan of regular activities they enjoyed.

Staff told us the level of activities had increased significantly in the last year. However, we saw an over-emphasis on 'chores'. One person's daily records showed that throughout January 2015 this person did chores daily which included sweeping up animal faeces, mucking out the stables and yard, sweeping various rooms including the dining room and classroom, doing personal chores such as laundry, mopping their room, and taking out recycling and rubbish. On most days they went on at least one and sometimes several walks. There was no evidence to show the person had chosen, or enjoyed these activities. On one occasion, when they were taken out to the beach they were described as "seemed happy".

People could also help with looking after the animals if they wanted, although staff told us most people did not enjoy animal care and had asked for the alpacas to be removed. One member of staff said people were sometimes forced to help with animal care, and gave an example of one person who thought they were being punished if they were forced to carry out animal care tasks such as mucking out the stables.

Other people's daily notes recorded chores carried out at least once a day, and frequently, more often. One relative said that when they had looked at the daily reports completed by staff these mainly showed the person's daily activities consisted of "chores, then walks around the

Inadequate

Is the service responsive?

building, then more chores". One incident record described how a person had been told by staff they must carry out their chores before attending a social activity in the community. In another person's daily record it stated "Prompted to clean and tidy bedroom, but appeared to ignore." Another person's daily records described "A good afternoon. Completed her jobs and drank all her tea in dining room without being reminded" on one day and "was reluctant to do anything this morning – took her time in completing her chores (started at 11.30am)".

People were taken out on walks locally and could also access the grounds of the home, where they could interact with goats, alpacas and a pony. However some people were taken out on several walks each day although there was no evidence that this was because they had chosen to do so.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the care and treatment of people was not always appropriate, did not always meet their needs, and did not always reflect their preferences.

There were facilities for a range of activities on-site including a day centre with various rooms for arts and crafts, computers, relaxation and a kitchen. Two rooms were being refurbished to provide a quiet activities room and a sensory room. A gardening club was planned to start in the near future. The day centre was intended for people who lived in the community who visited the home on a daily basis, although people who lived at Little Acorns could also use the day centre facilities.

People were not actively supported to raise complaints. One person described things they were unhappy about such as limited activities and restrictions on what they were allowed to do in the home. For example they told us "When I want to go out I can't always." They also told some "Staff are sometimes bossy and tease," and "There is very little activity."

People's views were not actively sought about the service and there were no systems in place to encourage people to raise concerns or complaints.

This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a record of one formal complaint from a family member since our last inspection. This had been appropriately actioned.

Inadequate

Is the service well-led?

Our findings

At the last inspection of the service in August 2014 we found there were poor systems in place to monitor the quality of the service. This meant the serious failings we identified during our inspection put people and staff at serious risk of harm. During this inspection the quality of the service remained poor and therefore the compliance actions had not been met. Insufficient actions had been taken to identify areas of poor service or to take actions to address them. The home was poorly managed.

Before this inspection we received concerns about the management of the service. We were told that a senior member of staff was "unorganised, has a profound lack of knowledge in regards to his managerial duties, and doesn't communicate with staff or service user's parents." During and after our inspection we received similar concerns from professionals, staff and relatives about senior staff who held responsibility for the management of the service.

Incident records and records of complaints showed there was a pattern of complaints and concerns relating to some members of staff. We asked two senior staff if they had investigated the incidents, complaints and concerns, and if they had considered any actions they should take as a result of their findings. They said they were aware of poor practice among some staff. However, they had failed to take any action. For example, supervision records for one staff member whose incident reports had raised concerns about poor practice showed they had received only one supervision session, six months previously. The supervision records were brief and did not identify any concerns regarding poor practice. Another member of staff had received no supervision since they began working several years previously. There was no evidence to show how they had discussed concerns about poor practice with the members of staff, or put in place any actions such as further training, regular monitoring or supervision. This meant that poor practice had been allowed to continue without being addressed or challenged.

Six staff contacted us and said they were not confident concerns and safeguarding incidents had been handled appropriately. They described concerns they had about people's care and safety which they had raised with senior staff. They said they were not satisfied their concerns had been taken seriously or the matters they had raised had been investigated or acted upon. They described 'bullying tactics' by the management team, and said staff were frightened to raise concerns for fear of losing their jobs. Eight other staff said they were confident they could speak with senior staff if they had any concerns relating to people's safety and felt these would be listened to and addressed.

Before this inspection a member of staff said "Staff are frightened of losing their jobs if they raise concerns." They also said "Staff have written down their complaints and (two senior members of staff) have conspired on what action to take against them, e.g. increase or decrease shifts or changing shift patterns." Two members of staff described how concerns and complaints had been raised in staff meetings but these had not been acted upon. Staff meetings prior to the inspection had not been minuted and therefore there was no evidence of the complaints being raised. One member of staff said they felt that senior staff considered some staff were "troublemakers" if they spoke out and raised concerns or complaints.

We saw three written complaints by staff referring to incidents and concerns which had occurred during periods when there were insufficient staff to meet people's needs. The complaints were not all dated although one related to incidents during January 2015 and we were told the others had been received in the previous three months. In one complaint a member of staff had said they had been left to support all except one person on their own while another member of staff worked with just one person. In another complaint one member of staff had taken a person to a medical appointment while two staff had been left to support all the remaining people in the home.

We asked a senior member of staff for evidence of their investigations into the three complaints but they said they were still in the process of investigating them, although they were unable to explain fully how they planned to do this. Although some complaints were undated we understood they had been received several weeks previously. This meant the complaints had not been investigated or acted upon promptly.

Systems were not in place to monitor and assess the quality of provision. The service did not have any methods to elicit the views and opinions of people using the service, their relatives or professionals who worked with them.

Inadequate

Is the service well-led?

Audits were not carried out to check that all areas of the service were running smoothly. For example, there were no systems in place to check the balances of stocks of medicines held in the home.

There were no systems in place to check balances of cash held on behalf of people or checks on money spent by staff on behalf of people. There were no systems in place to ensure staff were recruited safely, or that they were inducted and trained adequately.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff said there was a culture of bullying by senior staff. For example, one member of staff told us members of the management team were "on a power trip. They don't listen." Another member of staff described staff being belittled or spoken about in a negative manner in front of other staff and said they were so upset they were considering leaving. Another member of staff told us they had resigned because of the bullying manner of a senior member of staff. A relative also told us they had been bullied by a senior member of staff and they had been reduced to tears by their manner.

Some staff said they received good support while other staff described how they had asked for support and guidance from senior staff but this had not been provided. We also heard from staff that the staff team was divided. Some staff told us there had been divisions and disagreements because some staff were refusing to follow new ways of working. Other staff told us they were not given important information, and said only favoured staff were given this information.

Four staff said they were seriously concerned about the lack of communication from managers and the lack of supervision and support. They added that important information was not always passed on to them by the senior staff. However some staff said they were happy working there and enjoyed working with the people who lived in the home.

We found no evidence that the home had developed links with the local community. One person living in supported living had been involved in a local film event in 2014. However, there was no evidence that managers or staff had supported them in their involvement. An incident form described how a care worker had chastised the person for being too involved in the event. A senior manager said that they had asked the care worker to attend the event in the evening to support the person, but the member of staff had refused.

The provider should notify CQC if there is an incident which involves abuse, serious injury, death, police involvement or disruption to service. There were no statutory notifications from the home since 2011. When we reviewed the incident log, there were incidents which we should have been notified about, but had not been. This meant that opportunities to identify risks for individuals and poor care were missed. Senior staff said that they were not aware of this requirement but would do so in future.

We found that the registered person had not protected people against the risk of unsafe care, treatment or services. This was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was not on site during the first day of inspection. Although we observed them arriving on site on the second day of inspection, we did not meet with them and had no communication with them. We requested that they met with us on the third day of inspection, which they did.

At this meeting the registered manager, who was also the provider, said they had stepped down from day-to-day charge of the home and had put a senior member of staff in charge as the manager. They also said they had employed a deputy manager.

We found that the registered person had not protected people against the risk of records not kept securely to maintain confidentiality.

Some records had not been stored in a way that maintained confidentiality. For example, some care plan documents were kept in an unlocked cupboard in the kitchen in the day centre. The records contained confidential information relating to individual care needs. We spoke with a senior member of staff who said they would move the records to a lockable filing cabinet. We also found an unfiled assortment of records loose in boxes in the office. This included daily notes 'piled up' in a corner of an office that was not regularly used. There were some records relating to one person which had been stapled to another person's notes.

Inadequate

Is the service well-led?

We found records were badly filed and sometimes chaotic. For example, some documents in one person's care plans referred to another person. Information relating to another person's care was stored in at least two and sometimes three different files which were stored in different areas – this meant that staff did not have easy access to a current comprehensive assessment and care plan.

Records of people's money held in the home and handled by staff on behalf of people had been poorly maintained. The acting manager said that it was the responsibility of individual staff working with people and the standard of recording varied. There were no systems in place to make sure the records of cash and savings were regularly checked.

We found that the registered person had not protected people against the risk of inaccurate and incomplete records. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (c) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in August 2014 we found the provider had failed to adequately co-operate with other providers, including health and social care providers such as the GP and the Learning Disability team. During this inspection we found other providers had been recently involved with the service and had offered guidance and training to the staff.

Professionals who visited the home after our inspection said "There are clear indications that Little Acorns do not follow guidance from professionals, implement these in care plans and communicate them effectively when necessary." They gave examples of professional input to the staff for one person by a primary care liaison nurse who had worked specifically with key members of the staff team to discuss the person's individual issues and agree a framework for them to work within. There was no evidence of this lengthy piece of work in the person's care plan, and staff did not refer to the training or guidance when later questioned by visiting professionals.

There had also been involvement with the person by a psychiatrist who advised Little Acorns staff that a person may benefit from specialist input. Senior staff failed to mention that that this work had recently been provided by the primary liaison nurse, or that awareness training had been given to staff who worked directly with the person.

This was in breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence that the home had sought advice and treatment for one person from their GP appropriately.