Care Quality Commission

Mrs Susan Kay Hardman

Luke's Place

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection at Luke's Place on 17 November 2015. This service provides accommodation and personal care for up to 4 people with learning disabilities, physical disabilities or mental health conditions. At the time of our inspection there were three people living at the service.

A registered manager was not required at this location as the registered provider was an individual rather than an organisation and managed the service themself. An individual who is the registered provider is a 'registered person'. 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.

At our last inspection on 11 June 2015, the service was in breach of Regulations 9, 11, 12, 13, 16, 17, 18, 19 of the Health and Social Care Act (Regulated Activities)Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulation 2009. The service received an overall quality rating of inadequate, and was placed into Special Measures. We asked the provider to

Summary of findings

send us an action plan to tell us what improvements they were going to make to meet the regulations. They provided an action plan on 07 September which stated that they would achieve compliance with all the regulations by 31 October 2015 with the exception of Regulation 18 HSCA (Regulated Activities) in relation to staff training which would be compliant by 31 January 2016.

We carried out this inspection to check on the improvements made since the last inspection.

During this inspection we found that insufficient improvements had been made. We identified continued breaches of Regulations 9, 11, 12, 13, 16, 17, 18, and 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulation 2009. We also found breaches in Regulation 10 and Regulation 20A of the Health and Social Care Act (Regulated Activities) Regulations 2014. As a result, the service is still rated as inadequate and remains in special measures. You can see what action we told the provider to take at the back of the full version of the report.

There were sufficient numbers of staff on duty although some staff had not received effective training to ensure they had the skills to support people. Staff and the provider did not demonstrate an understanding of, or meet, the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards.

Staff recruitment processes were not safe.

Risk assessments were not regularly reviewed and did not contain sufficient information.

People had enough to eat and drink and had access to health care services as appropriate, although advice from health care professionals was not always followed.

Staff did not always show respect for people and their confidentiality was not always upheld.

People and their representatives were not always supported to make decisions and were not sufficiently involved in assessing their needs and planning their care.

Relatives were aware of the provider's complaints system and information about this was available in easy read format. The provider did not respond to complaints appropriately or in line with their policy.

The provider did not promote a positive and open culture where people and their relatives were involved in developing the service.

The provider did not demonstrate strong visible leadership or give consistent direction to the staff team.

The provider did not have effective systems in place to assess and monitor the quality of the service.

Special measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

Staff did not all have an understanding of processes to safeguard people from harm and concerns were not always reported to the Care Quality Commission (CQC) or the local authority appropriately.

Staff recruitment practices were not safe.

Individual risk assessments were completed but did not contain sufficient detail and were not always updated regularly.

Environmental assessments had not been completed in relation to some areas of risk.

Medicines were administered and stored safely.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not all kept up to date and some training that had been completed was not effective.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards were not met.

People had enough to eat and drink.

People were not always supported to maintain good health.

Is the service caring?

Inadequate

The service was not caring.

Some staff did not engage well will people, although others did.

Some staff spoke to people in a childlike manner which was not respectful.

People and their representatives were not sufficiently involved in making decisions about their care and their confidentiality was not always maintained.

People were not supported to participate and maximise their independence and control over their own lives.

Is the service responsive?

Inadequate

The service was not responsive.

People and their representatives were not involved in assessing their needs and planning their care.

People's individual needs were not always met and care plans were not effectively updated.

Summary of findings

People and their representatives were aware of how to make a complaint but did not all feel that complaints would be appropriately acted upon.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not formally notify us of significant events in the service as required to by law.

The provider did not promote a positive and open culture where people and their relatives were involved in developing the service.

The provider did not demonstrate strong visible leadership or give consistent direction to the staff team.

The provider did not have an effective system for assessing and monitoring the quality of the service they provided.

Luke's Place

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 on the improvements made to the service following our inspection in June 2015 and 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 17 November 2015 and was unannounced. Two inspectors carried out the inspection.

Before the inspection we received information of concern that the service had not improved since our last inspection and that many issues identified remained unresolved. We also reviewed information we held about the service. This included information we had received from the local authority and the provider since the last inspection, including any action plans and notifications of incidents. A notification is information about important events which the provider is required to send us by law. We had not received any notifications from this service.

During our inspection we spoke with all the people who used the service but due to their complex needs they were not able to tell us in detail about their experience so we used observation to help us understand. We also spoke with one relative of a person who used the service, the provider who also manages the home (the manager), the administrator, a senior support worker and three support workers. We reviewed the care records of all of the people that used the service. We checked medication administration processes, staff training and recruitment records and we reviewed evidence to demonstrate how the provider assessed and monitored the quality of the service provided.

After the inspection visit we spoke with a further two relatives of people who use the service by telephone and attended a meeting with health and social care professionals who worked with the home and gained feedback from them about the quality of the care provided.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2015 we found that the provider had not always reported incidents of concern to the Care Quality Commission (CQC or the commission) or to the local authority as required by law. We found the provider did not have a robust recruitment process in place. We looked at the recruitment documentation for six members of staff and found missing or delayed information in all of them. We also found that risk assessments were not reviewed when required and did not contain sufficient information.

At this inspection we found that the provider had not notified The Commission about an incident that took place on 24th June 2015, which was the subject of a safeguarding investigation. Information about abuse and how to report any concerns was not on clear display in the service. Staff were unable to locate information about who to contact to report concerns and we found that some staff did not have an understanding of their responsibility to protect people from abuse. They did not know what the different types of abuse people might experience were or what signs they should look for that could indicate the person had been abused. When asked, they told us that safeguarding was about protecting people from fire. Staff were not able to tell us whether the provider had a whistle blowing policy but did say, when prompted, that they would inform the provider if they were concerned about the conduct of a colleague.

People remained under continuous supervision but no action was evident that any steps had been taken to ensure that the legal framework to protect people had been applied. The provider told us that one Deprivation of Liberty Safeguards (DoLs) application had been made but we saw no evidence of this on the person's file and no mental capacity assessment to support the application. In the absence of clear strategies to support one person to manage behaviour which had an impact on themselves and others, staff used threats that the person would be prevented from going out. This did not protect the person from the risk of being unlawfully restricted.

We were not confident that staff or the provider had the skills or knowledge necessary to recognise signs of abuse, what constitutes an incident of abuse or how to report safeguarding concerns appropriately.

This was a breach of regulation 13 of the Health and Social Care Act (regulated activities) Regulations 2014.

At this inspection we looked at seven staff records and found missing information in five of them. The provider told us that the missing references had been received but was unable to locate them and therefore we were not able to verify this. This put people at risk because the provider had not taken reasonable steps to ensure, as far as possible, that they were cared for by suitable staff.

This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

There were individual risk assessments which identified how the person was at risk and the steps put in place to minimise the risk were documented. However, risk assessments had not been regularly reviewed and, as at the previous inspection, we found that the steps to minimise risks identified the training staff required rather than focussing on the individual's needs. We also noted the assessments did not identify how people would be supported to be as independent as possible and people were not involved in deciding which risks they wished to take.

Some risk assessments in relation to the environment had not been completed, such as risks associated with legionnaire's disease. We also noted that routine fire checks had not been consistently completed.

Records of incidents were kept although it was not clear whether or not all incidents and accidents that took place were recorded as the provider did not have a formal system for analysing them. We were not confident that they would be able to identify patterns and trends to ensure appropriate action was taken to reduce the likelihood of further incidents in the future.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that staff were, "Nice" and that they not scared at Luke's Place. Some relatives told us that they felt the people were safe and that staff were trustworthy, although others expressed concern that the care provided to their family member was not safe. Relatives told us that there were usually enough staff on duty to support people safely but that this was not always the case, particularly at

Inadequate

Is the service safe?

weekends. The provider told us that there was always a minimum of four staff on duty during the day and two at night but this number was likely to reduce to three staff during the day as there were now only three people living at the home. The provider told us that the number of staff was flexible depending on whether activities were taking place such as bowling or swimming. Staff absences or vacancies were covered by the regular staff picking up extra shifts to ensure that people were supported by familiar staff. On the day of our inspection there were enough staff on duty.

The provider had produced individual personal emergency evacuation plans for people who used the service.

People's medicines were administered safely. People were assessed to establish if they were able to manage their own medicines although, because no one was doing this, staff administered them. The system in place enabled an audit of the administration of medicines to be undertaken and we saw that, where errors had occurred, appropriate action, including retraining of staff members concerned, was taken. Storage of medication was in line with current good practice. Staff who administered medicines had received training to ensure they understood and were competent to do so.

Inadequate

Is the service effective?

Our findings

At the inspection in June 2015 people and their relatives told us that support from staff varied and that some staff were more skilled than others. We found that training had not been provided to staff in relation to some people's specific needs and that essential training, such as safeguarding people from harm, first aid and health and safety had not been completed or was out of date for many staff. Staff did not receive regular supervision. We also found that the provider and staff were not working in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Most staff had not received any training in relation to the MCA and DoLS and did not have an understanding of this legislation. No mental capacity assessments had been completed and no DoLS applications had been made, despite the provider telling us that people lacked the capacity to make certain decisions. We found that people had not consented to care and support and family members had been asked for their consent rather than the person. We also found that people had not been supported to access healthcare services in a timely manner and this had resulted in one person's admission to hospital.

At this inspection, we found that sufficient improvements to these issues had not been made. Due to the complex needs of the people who used the service, they were not able to tell us about whether or not staff supported them effectively. All of the relatives we spoke with said that support from staff continued to vary. Experienced staff were seen as good, but most relatives commented that a high turnover of staff meant their family member often received care from less experienced members of staff, who did not always have the necessary skills to meet their needs. One relative said, "When [name] was here it really was good. It's not the same. So many of the good ones have gone. The new ones are okay, but they don't know [family member] as well."

We saw that one person was not being supported to use a specific piece of equipment that could enable them to communicate their needs. When asked staff told us that the equipment was in the person's room. The person's relative told us that staff did not know how to use the equipment so it was not offered to the person. We looked at the provider's training record and this did not show any evidence of training for staff in the use of the equipment.

A family member expressed concern that staff lacked the skills and training to support their family member appropriately regarding their moving and handling needs. They told us that they had raised this with the provider who told them that they personally did not have knowledge in this area either. Staff had received standard one day moving and handling in care training, which the provider told us would have considered the needs of people using the service. However, we saw no evidence that specialist training in relation to the person's requirements had been arranged and the risk of inappropriate and unsafe care for this person was not fully addressed. Due to their specific physical needs, this presented a risk of serious injury to the person.

The provider had made some progress towards bringing training up to date although some training was still overdue. Some training that had been completed was not effective as staff were unable to answer basic questions about issues such as safeguarding people and Mental Capacity. Most training provided was completed through an e- learning programme, and although staff were required to take a test at the end of training to check their understanding, the provider had not monitored staff's understanding beyond this.

The provider had no previous experience of managing care homes and did not have any management qualifications. This put people at risk of unsafe care because the service was not run by a suitably qualified and experienced manager and care was not provided by suitably skilled and experienced staff.

These issues were a continued breach of 18 of the Health and Social Care Act (regulated activities) Regulations 2014.

We found that the provider and staff continued to have insufficient understanding of the MCA and DoLS. One member of staff told us that they had the training but did not understand it. They told us that DoLs was, "About confidentiality." DoLS aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

MCA assessments had not been completed although the administrator told us that an unknown doctor had

Is the service effective?

assessed one person as not having capacity. However, they were unable to confirm what decision this related to and there was no evidence of an assessment on the person's file.

We reviewed care records for all of the people who used the service and found that they had not consented to their care and support. No best interest process was documented on any person's file although it was clear that decisions were being made on their behalf, where it was thought they lacked capacity to consent to treatment themselves. For example, one person required a device to treat a medical condition. They were not comfortable using the device and regularly removed it. This was a complex situation because non - compliance with treatment carried a high risk for the person. However, there was no mental capacity assessment to assess whether the person had the capacity to understand the consequences of not using the devise and no best interest decision recorded to give clear direction to staff about how to support the person's needs.

These issues were a continued breach of regulation 11 of the Health and Social Care Act (regulated activities) Regulations 2014.

We saw from care records that people had been supported to attend routine health checks, such as GP and opticians appointments and we saw that one person had recently been assessed by a speech and language therapist. However, we found that staff did not consistently follow the advice provided by health care professionals. For example, one person had been assessed as requiring a straw to drink safely. We saw that the person was offered a drink with a straw but they did not use it. A relative told us that staff frequently forgot to offer the straw unless reminded. This may have led the person to be confused over the purpose of the straw and meant that they were at risk of not receiving effective care with regard to drinking.

Some relatives felt there was an improvement in how their family member's health care was supported in recent months as no incidents of poor health had occurred. However, they expressed some concern about the possibility of incidents in the future. We spoke with a member of staff about the health needs of people who used the service and found they were unable to identify some of the serious known risks related to some people's needs. People were therefore at risk of their health needs not being appropriately met because staff did not have the skills or knowledge with which to support them effectively and did not consistently follow professional advice.

This was a further breach of regulation 12 of the Health and Social Care Act (regulated activities) Regulations 2014.

The senior support worker had carried out supervisions since the last inspection. However, there was an expectation that they would complete supervision for all 17 staff members. This made it unlikely that it would be given priority in the long term due to the amount of time this would take if completed effectively. The provider told us that they were going to be conducting staff appraisals but this had not been completed yet.

People had enough to eat and drink and we saw that food and drink was freely available to people whenever they wanted it. Relatives told us that people had enough to eat but that the quality of the food varied according to who was on shift because some staff relied on pre-cooked food rather than home cooked meals. We saw that the provider had produced pictures of different foods to support people to choose which meals they wished to eat. One member of staff was taking a lead role in meeting people's nutritional needs and supporting them to eat a healthy balanced diet. However, they said this was not always well supported by the rest of the staff team. The provider told us that referrals were made to a dietitian when any concerns about people's dietary needs arose.

Inadequate

Is the service caring?

Our findings

Relatives had mixed views about the care their family member received and many relatives told us they felt care at the service was not as good as it used to be when the service first opened. Some people attributed this to the loss of more experienced staff who knew people well. All the relatives we spoke with said that staff intentions were good and that staff were mostly kind and caring.

We observed that some staff showed little interest in engaging with people and sat in silence when in the same room as them. We also observed numerous occasions during which staff spoke to people in a childlike manner. For example we heard staff telling a person, "I don't want to see all that silly nonsense" and "Are you going to behave yourself?" All of the people who used the service were adults and it did not demonstrate respect for them or uphold their dignity to speak to them in this manner.

Although we saw that staff offered choices to people, we found that the manner in which this was done did not support people to have their preferences met. For example, at lunchtime, one person was asked what they would like for lunch, to which they answered, "[Name of food]" The staff member then asked if they would prefer something different, such as a sandwich. The person repeated, "[Name of food]." This was still ignored. Two more staff then became involved, making suggestions and showing the person pictures of food to choose from. The person pointed to a picture of quiche and salad and it was agreed that they would have this for lunch. However, staff found that there was no quiche available. Asked again what they would like, the person still said that they would like [name of food]. The person was eventually given a sandwich, which was what the staff member had wanted to give them, and the clear choice they made was ignored. This demonstrated that although people were asked to make choices, the choice they made was not always respected. We discussed this with the provider, who had been present when this happened. They told us they believed staff were anxious about doing the right thing in front of inspectors and the offering of so many choices was "for CQC's benefit."

A family member expressed concern that their relative was losing their skills because they were not encouraged to participate or maximise their independence. They said, "[Person] is losing skills. They don't give [them] anything to do, they just do it all for [them]. [Person] used to do a lot for themself, or at least with support. They don't know [person's] capabilities." On the day of the inspection we observed that staff missed opportunities to involve people or to support people to complete tasks independently. This did not support people to maximise their independence or to take control over their lives.

People's confidentiality was not always maintained. One family member told us that the provider had discussed information with them about a person who used the service that was not related to them. They went on to say, "It makes you wonder who they talk to about [family member] and what they say about us." We noted that the layout of the building made it difficult for people to meet in private. This did not uphold people's privacy.

This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Although some staff did not engage well, we observed some other staff interacting with people in a caring way. We saw that they were attentive to people and chatted with them about day to day matters. There was a relaxed atmosphere in the home and people appeared at ease in the company of staff.

We saw that people were supported with personal care in a manner which upheld their privacy and dignity. Support was offered in a discrete manner and personal care was provided behind a closed door.

People were supported to maintain relationships with people that were important to them. Staff told us that people's friends and relatives were able to visit at any time and that people were supported to go to their family home for visits if this is what they wished to do. Relatives confirmed this, but also commented that there had been occasions where they or other family members had not felt welcome, particularly following raising any concerns about the service.

Inadequate

Is the service responsive?

Our findings

At our inspection in June 2015 we found that people and their family members had not been involved in planning their care and had not had sight of their care plan. Care plans we looked at had not been updated to take account of changes in people's needs or in response to incidents that had taken place. They did not contain sufficient information about people's individual needs to ensure staff met people's needs well and care for them safely. Some people who required support to manage behaviour that may have an impact on themselves or others did not have care plans in place to guide staff on how to do this. We found that activities were not planned to take full account of people's interests and hobbies and that there was a lack of opportunities identified for people to be engaged in meaningful activities that maximised their independence. We also found that the provider did not have systems and processes in place to receive and handle complaints appropriately. At this inspection we found that sufficient improvements had not been made.

We looked at the care plans for all of the people who used the service. We found that a review of care plans had been started and each record contained a summary section with information about the person's daily routines such as how they liked to be supported with personal care. However, we found that some information had not been updated to include changes in people's preferences. For example, one person's plan stated that they wished to have support to take a bath, although we were told by the provider that the bath was due to be removed as the person only liked to shower.

The main content of each person's care plan remained similar to those seen in June and lacked personalisation or any evidence of involvement from people and their family members. Family members we spoke with confirmed that they had not been involved in their development and continued not to have had sight of the documents at any time. One relative said, "I've still never seen a care plan, although I have repeatedly asked. I was not involved in it and have never seen it. They are locked away. Even staff can't get to it sometimes." The provider told us that the next step of the process would be to show the care plans to people and family members. This demonstrated a failure to understand good practice in relation to person centred planning which should encourage people to be involved from the start of the process.

The administrator told us that the new care plans were not finished yet and what we saw was a work in progress. However, after five months since the last inspection, the progress towards improving care plans was minimal. Professionals who worked with the service told us that a lot of support had been provided by them with regard to this work but it had become clear that the provider did not grasp what was needed to improve the plans. The revised care plans were not yet in use and the previous care plans were stored in a manner which meant they were not always accessible to staff.

Although some work had been completed to improve the guidance in relation to one person's medical and health needs, vital information such as the signs to indicate a dangerous decline in health were not included. No incidents of ill health had occurred since the last inspection and this person's relatives told us that they thought staff were more aware of their needs than they had been previously. However, one member of staff that we spoke to about this person's needs did not show an awareness of their medical conditions or how they needed to be supported in relation to them.

Strategies had still not been developed to guide staff on how to support a person to manage behaviour which had an impact on others and the person themselves. As a result we saw staff intervening in a manner which clearly escalated the person's distress and potentially put themselves or others at risk.

There was some evidence of improved activity planning since June 2015, although the timetable shown to us was not carried out on the day of the inspection. One family member said, "I think [person] is going out a bit more but it could still be better." Another family member told us they were concerned about the lack of meaningful activity offered to their relative. They said, "They tell me [person] goes out every day, but I say, well maybe for an hour and a half, but is that all [they] have to look forward to? What about the rest of the time?" They went on to say, "There is no structure and no person centred activities. It is neglectful and [person] is losing their skills." During the inspection we noted that the person was watching television with a staff member who was sitting behind them

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Is the service responsive?

focussed on their mobile phone. Another person was playing music in the same room as the person who was trying to watch television. One person who was scheduled to go out did not do so because the provider was assisting the inspection. We made several attempts to encourage the provider to go out with the person as planned but this was not successful. In the afternoon, staff suggested that one person might like to make cakes, which they agreed to do. However, despite this being discussed several times, it did not happen by the time we left the service in the evening. We concluded that people were not sufficiently supported to participate in meaningful activities or in pastimes that were of interest to them.

All of these issues were a continued breach of regulation 9 of the Health and Social Care Act (regulated activities) Regulations 2014.

The provider confirmed that no work had been undertaken to improve practice in relation to receiving and handling complaints. Family members told us that complaints were not dealt with appropriately and often were not responded to at all. One relative said that the provider usually noted concerns on a scrap of paper and, “That will be the last you hear of it.” They told us that communication was, “Still dire”, and that, although the provider had responded to emails for a while following the last inspection, they had now stopped responding again. A complaints form was in use at the service but these were not used consistently and the provider did not have a system for managing complaints. This made it difficult for the provider to learn from complaints and use the information to improve the service offered to people.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our inspection in June 2015 we found that the provider did not have a sufficient understanding of their role and legal responsibilities in relation to both leading the service and monitoring the quality of care. A Quality Monitoring Policy was in place in the service but the provider was not aware of its existence and it was not being followed. Systems to monitor the risk to people's health, safety and welfare were either not in place, not effective or not kept up to date. The provider did not give clear direction to staff and staff commented that the provider was inconsistent. We found that documented guidance to staff about how to meet service user's individual needs was not adequate. We also observed that there was a lack of clear leadership by the provider who appeared to defer to senior staff. Staff were not provided with adequate training or supervision to perform their duties properly. As part of the inspection we contacted health and social care professionals who worked with Luke's Place. Without exception, each professional raised similar concerns to those identified during the inspection in relation to the management of the service and the quality of the care provided to the service users who lived there. Following our inspection, a monitoring visit was carried out by Hertfordshire County Council during which similar concerns to those identified at our inspection were found. The visit resulted in a poor rating with a score of 34%.

At this inspection we found that sufficient improvements had not been made to the management and leadership of the service. The administrator told us that they were working on an audit system but it was not yet completed. When asked they were not able to produce any evidence of this work. This meant that, apart from a system to monitor medicines management which was in place in June, there were no systems or processes in place to check on the quality of the care provided to people.

We looked at the policy folder and found it had not been updated since 2010. Again, the administrator told us that they were in the process of undertaking a review of all policies and procedures. However they were unable to produce any evidence to support this.

The provider continued to demonstrate poor leadership ability and knowledge. They had not secured a place on a management training course or made any attempt to address this and improve the management arrangements for the service. They had a poor understanding of many issues related to the provision of care. This included a lack of understanding about care planning, person centred care, the requirements of the Mental Capacity Act and the theory of safeguarding people and the processes that support service providers to do so.

Staff did not receive support to do their job well. Although supervision was now taking place, the frequency of this for staff was likely to be adversely affected because the senior worker was expected to conduct supervision for all 17 staff members. The provider told us they were going to complete appraisals but this had not happened yet. The provider did not monitor the effectiveness of staff training and, although they were aware of staff who had not understood training that they had completed, they had not done anything to address this. The provider told us that they were aware that some staff had not completed training and referred to them as "A lazy lot." However, they failed to recognise that it was the manager's responsibility to ensure training was undertaken.

Relatives told us that the provider was very disorganised and that as a result the service was chaotic. One relative said, "It is very haphazard." Another relative said, "The place is terribly disorganised and so is [Provider's name]." We found that records were not kept securely or in an organized manner which enabled them to be utilized effectively. When we asked to view documents, such as certificates and employee references, the provider told us that they were 'around somewhere'. When asked, they were also unable to find the June 2015 inspection report and only found it after a considerable search. In contrast, relatives reported that staff were frequently unable to access care plans because they were locked away in the office and, if the provider was not on duty, they could not unlock the door.

Some relatives said that the provider was not consistently professional and did not deal with issues in a manner they would expect from the manager of a service. The provider did not promote an open culture which supported person centred practice. Although they claimed to be approachable and stated they had a preference for informal communication with people and their families, relatives did not always feel that communication with the

Inadequate

Is the service well-led?

manager was easy. Relatives were not routinely asked for their views and told us that when they raised issues for discussion with the provider no action was taken and no feedback received.

As they had previously in June 2015, both relatives and professionals perceived that the provider had conflicting priorities due to their family connections with one person who used the service. Many continued to feel that that this had a detrimental impact on the experience of people who used the service. We observed this to be the case during the inspection where the provider clearly felt torn between the needs of their family member and their role as the provider feeling responsible for facilitating our inspection.

All of these issues were a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We noted that the provider had not displayed their rating following the last inspection as required by law. They stated that they had not received a poster. However, the standard letter sent with the final report gives providers instruction on how to download this poster from the website. It is the provider's responsibility to ensure this is done.

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

The provider failed to notify us of a significant event that took place on 24 June 2015 which was the subject of a safeguarding investigation by the local authority.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not involved in planning their care and their preferences were not identified .They were not sufficiently supported to make decisions about their care and their individual needs were not always met. Regulation 9 (1), (2) and (3) (a-g)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered provider did not take appropriate steps to ensure people's confidentiality was maintained or that people were treated with dignity and respect. Regulation 10 (1) (2)(a) and (b)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 and the associated Deprivation of Liberties Safeguards.

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Risk assessment were not always updated and did not contain sufficient information to support people safely. Some risks were not clearly identified and important information was not included. Regulation 12 (1), (2) (a0, (b) and (i)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

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 registered person did not utilise systems and processes to report allegations of abuse of improper treatment effectively. Staff did not understand what safeguarding people involved, how to report safeguarding matters or what signs to look for that abuse may have occurred. People were not protected from the risk of unlawful restrictive practice. Regulation 13 (1-7)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not identify receive, record or handle or act on complaints appropriately, Regulation 16 (1) and(2)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.

This section is primarily information for the provider

Enforcement actions

The provider did not have effective systems in place to monitor the quality of the service, and did not actively seek the views of people and their relatives to make improvements to the service. The provider did not demonstrate effective leadership skills Regulation 17 (1), (2), (a),(b),(e) and (f)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not taken reasonable steps to ensure they or their staff had appropriate training and support. Regulation 18 (1) and(2)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered provider did not have a robust recruitment process which included all appropriate pre-employment checks Regulation 19 (1)(a),(b),(c), (2) (a) and 3 (a)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Regulation

Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments

The provider had not displayed the rating given at the previous inspection within the service or on their website. Regulation 20A(1), (2), (3), (4), (5), and (7)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider failed to notify the care quality commission of notifiable incidents within the service. Regulation 18 (1),(2) (b) and (e)

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.