Care Network Solutions Limited

Avon Lodge and Avon Lodge Annex

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected on 26 June and 2 July 2018. The inspection was unannounced on both days.

At the last comprehensive inspection in January 2018, the provider had breached four regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, staffing, recruitment and overall oversight of the home. We issued a warning notice around the governance of the service telling the provider to take action to make improvements. Following the inspection, we received an action plan and we also met with the provider to discuss the action they were required to take.

We planned to carry out a focused inspection to check the provider had followed their plan and to confirm that they now met legal requirements in relation to governance. However, at this inspection we found new and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We therefore made the decision to carry out a comprehensive inspection on this occasion, not a focused inspection as planned. You can see what action we told the provider to take at the end of this report.

This service was rated Requires Improvement in January 2018. The service has been rated Requires Improvement at this inspection. This is the fourth consecutive time the provider has failed to achieve a Good rating. We will communicate with the provider outside of the inspection process to understand what action they will take to improve their overall rating to at least Good.

Avon lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Avon lodge can accommodate up to 12 people. Ten people lived in Avon Lodge when we inspected.

Avon Lodge Annex is a service which can provide personal care to people living in a 'supported living' setting, so they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living. When we visited, people living in Avon Lodge Annex were not in receipt of 'personal care' and we were not authorised to review their care.

Avon lodge and Avon Lodge Annex are two buildings next door to each other. The service can support people with mental health concerns and learning disabilities and/or autism spectrum disorder.

The provider had failed to evidence they met the values that underpin the 'Registering the Right Support' and other best practice guidance such as 'Building the Right Support'. These values include choice, promotion of independence and inclusion. Also, how people with learning disabilities and autism using the service can live as ordinary a life as any citizen. We will communicate with the provider outside the inspection process to understand how they intend to meet 'Registering the Right Support' policy and

associated best practice guidance.

The registered manager had left employment since the last inspection. Therefore, a registered manager was not in post when we inspected. The commercial director and regional operations manager were responsible for the day to day management of the home when we visited.

A new manager had been recently recruited and commenced the process to register with the CQC. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and key staff had left since our last inspection. This meant the provider had gone through a difficult period and managed a crisis. The provider had delegated senior managers to be present each day to ensure leadership was in the service. Agency care workers who had worked previously in the service were sought to ensure some stability for people. The provider also deployed experienced staff from their other services to bring knowledge and stability to the service.

This had ensured the level of risk to people's immediate safety had been reduced and maintained. However, staff had not received a robust induction or training, which meant they did not know people who used the service. We found people had not received a person-centred service based on their preferences and needs. People told us they felt safe, but that the staff changes meant they felt unsettled.

Throughout this period the provider had maintained focus on delivering positive change. They were committed to providing a good quality service for people, but admitted that because the huge task of staffing and culture change had taken such investment that progress was not as quick as anticipated.

We could see that three people had benefited from increased communal activities, emotional support and investment in their support. However, the outcomes of the support people received was not always positive and five people had experienced poor care, such as lack of support with personal care.

The provider was clear that they needed to start with the basics of support provision and build the service to deliver the high standards they expected. We saw people were at ease in their environment and confident speaking up. People told us staff treated them in a kind and caring way with respect. We observed positive interactions between staff and people also. We felt this was a positive basis to build from.

The provider had been transparent since the last inspection and had worked alongside the local authority and the CQC to ensure all agencies were aware of the progress being made. The quality assurance system had picked up on issues we also noted around improvements to health support, record keeping and activities.

The renovations to the building had been completed and people were pleased with the space they now lived in. Safety checks had been completed. Arrangements in place to ensure people received medication were safe overall. More detailed protocols were required to ensure 'as and when required' medicines were given at the right time for the right reason.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. The records to evidence this required improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all staff knew the key safety information about people such as their health needs.

Recruitment checks were carried out appropriately. Agency worker profiles did not contain all the information required to confirm their identity and skills.

Arrangements in place to ensure people received medication in a safe way were safe overall. More detailed protocols were required to ensure 'as and when required' medicines were given at the right time for the right reason.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had received appropriate induction, training and supervisions to enable them to support people to achieve good outcome and a good quality of life.

People were supported to make their own day to day choices. However, records to confirm choices made on behalf of people and in their best interests were not clear.

Records relating to people's health were poor and the recommendations professionals made were not always followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by caring staff who respected their privacy and dignity.

Staff were not always able to describe the needs, likes, dislikes and preferences of people who used the service. This meant care and support was not always individualised to meet people's needs

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have consistent access to meaningful activities, particularly in the community. This area was not monitored effectively to understand the outcome for individuals.

Care plans contained person centred details about people's preferences, however staff were not always aware of these details. People and their relatives were not always involved in the development and review of people's care and support.

People and their relatives knew how to raise concerns. The provider needed to recognise and instigate the complaints process when needed.

Is the service well-led?

Inadequate

The service was not well led.

No registered manager was in post. A new manager had been recruited and positive feedback had been received from relatives about them.

The quality assurance system had effectively highlighted most of the concerns raised within this report. Action plans were used to monitor progress.

The provider had managed the service through a recent crisis and was committed to the continuous improvement of the service.

The provider had failed to notify the CQC of the people authorised to be deprived of their liberty as is required by law.

Avon Lodge and Avon Lodge Annex

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.

We inspected the service on 26 June and 2 July 2018. This was an unannounced inspection on both days. On day one, the inspection team consisted of three inspectors. One inspector visited on day two. We initially visited to carry out a focused inspection to check the provider had followed their action plan following the last comprehensive inspection in January 2018. However, due to concerns identified we completed a comprehensive inspection on this occasion.

Before the inspection we reviewed all the information we held about the service. This included information we received from safeguarding and statutory notifications, and updates the provider had sent us since the last inspection. We sought feedback from the commissioners of the service and visiting professionals prior to our visit. We used all this information to plan our inspection.

The registered provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were 10 people who used the service. We spoke with nine people and three of their relatives. We spent time in the communal areas and observed how staff interacted with people and some people showed us their bedrooms. We did not use the Short Observational Framework for Inspection (SOFI), because people were able to communicate with us effectively. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the visit the visit we spoke with the commercial director, regional operations manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with seven care workers, some of whom were agency care workers.

During the inspection we reviewed a range of records. This included five people's care records, including care planning documentation and medication records. We also looked at two staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Requires Improvement

Is the service safe?

Our findings

At the inspection in January 2018 the provider had not completed appropriate assessments to ensure safety. In addition, staff did not have the appropriate skills and competence to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some improvements had been made to records. People's care plans had been reviewed and updated to ensure information was available for staff to follow to maintain safety. However, staff were not always aware of the details contained within people's care plans and risk assessments. This meant they did not know key safety information about people's health needs, mental health concerns and support needs. For example, staff were not able to tell us how they would react in an emergency if a person required support around their diabetes. One member of staff told us, "To be perfectly honest I have not read all of the care plans." Professionals had observed incorrect food items being given to people, which would affect their health. Records were not completed robustly to evidence monitoring of weight, diet and behaviours people displayed. For example, a risk assessment for one person stated they should be weighed monthly and this had not happened.

Staff lack of awareness of people's needs meant people were at risk of harm. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the inspection in January 2018, the provider had not operated safe recruitment processes. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and this meant the provider had achieved compliance with Regulation 19.

One member of staff had been recruited since the last inspection and appropriate checks such as references from previous employers and police checks had been carried out.

The regional operations manager had received profiles from the staffing agency, which outlined the basic skills the agency worker had. The regional operations manager had used these to determine whether the agency worker was suitable. However, robust information was not available on the profiles such as the agency workers full work history, right to work in the UK and relevant qualifications or training. The regional operations manager told us they would seek to have all profiles updated to help them understand each agency workers skills and knowledge.

Although the regional operations manager had copies of agency profiles, these were not available in the service for staff to use to determine agency workers identity when they arrived for a shift. The regional operations manager explained all the agency workers were known by staff, however they agreed to ensure profiles were accessible in the service.

The provider had used a tool to determine the number of staff required on shift to make sure people

received appropriate support. On day one of the inspection staff on shift did not know how many staff should have been on duty and where they were allocated to work. The duty rota did not clearly evidence who should be on shift, because full names and roles were not always recorded. The commercial director agreed to ensure the document was clear and complete. We observed the number of staff on shift was enough to ensure people were monitored and supported.

People told us how the turnover of staff had affected them. They said, "There has been a lot of staff coming and going, we are seeing lots of agency", "It's a bit hectic, with staff coming and going and lots of agency staff, some stay longer than others" and "I am not getting close to any staff now because they leave." A relative told us, "There is all new staff and a manager and nearly all are agency. Time will tell if things will get better. My family member is struggling now because they need encouragement from staff, which does not happen. They are low at the moment." Another relative told us, "The service has been pretty poor lately. A complete change of staff and different people getting to know my family member. They are a little unsettled."

We discussed the volume of staff changes with the nominated individual, regional operations manager and commercial director. They told us they had worked to ensure the staff employed had the right approach to the support they wanted people to receive. Some of the staff were no longer employed because the provider had challenged their way of working. They also explained they were conscious of the need for stability and that they ensured one of them was on shift each day to direct staff in their duties. They had recruited a manager and senior who were due to start employment in July 2018. Members of staff who worked in the provider's other services had also been used to ensure skilled staff were available to support people. The impact these issues had on the effectiveness of support for people are outlined in the Effective section of this report.

On day one the commercial director showed us an allocation sheet they had started to implement, which clearly showed which staff were delegated to support each person. The allocation sheet did not clearly define all of the needs of each person so staff would know the main risks and any one to one support they may require. On day two they had updated the allocation sheet to include all essential information. The commercial director explained this had been introduced at each handover so staff understood their roles better.

Arrangements in place for the management, storage, recording and administration of medicines were safe overall. People were happy with the support they received. One person said, "I am positive my medicine is given on time. I have a medicine cabinet in my room locked all the time and staff have the key." Staff administering medicines supported people to understand what their medicine was for and checked the person understood. Where errors were found, these were recorded and the root cause investigated to reduce the likelihood of a reoccurrence. All staff who administered medicines had received a competency check from the provider in one of their services, but not at Avon Lodge. We discussed with the commercial director the need for each staff to know the specific medicines of the people living at Avon Lodge and they agreed to start completing medicine administration competency checks for the staff immediately.

The provider completed regular checks of the medicine system and the compliance in this area had improved since their first check in March 2018.

We looked at medicines which may be used 'as and when required' to support people when they were distressed or anxious. There were protocols in place, but they did not link to people's positive behaviour care plans to help staff understand at what point to administer them. We saw one person had been given this type of medicine on three occasions and records were not clear around the reasons why. The regional

operations manager said staff had called the senior managers for authorisation before administering this medicine. However, we could not determine that the medicine had been used as the last resort when all other positive interventions had failed. The regional operations manager agreed to create more detailed guidance for staff in this area.

Where people could become anxious or distressed, they each had a care plan which described the best way to support them. Records were not always completed to help understand what may have caused the distress and for staff to learn from situations and provide better support for people. This was discussed with the regional operations manager and commercial director. They agreed the records and analysis of incidences required improvement and that they would implement changes immediately.

The regional operations manager and commercial director understood about safeguarding adults and the action they would need to take if they witnessed or suspected abuse. All incidences were recorded and the service worked with the local authority and other agencies where necessary to support investigations. Staff we spoke with said they would have no hesitation in reporting safeguarding concerns and they described the process to follow.

People told us they felt safe and free from discrimination and harassment. One person said, "Yes I am safe." When we asked another person, they gave us the thumbs up indicating they felt safe. Another person told us, "I am happy here."

Records confirmed checks of the building and equipment were carried out to ensure health and safety. The service was clean, equipment and processes were in place to prevent the spread of infection.

The fire officer visited on the first day of our inspection to review the systems in place since the recent renovations. The fire officer gave the nominated individual feedback around how they could improve certain areas of the environment and fire evacuation process. The nominated individual confirmed following the inspection that all actions to improve fire safety had been completed.

Requires Improvement

Is the service effective?

Our findings

At the inspection in January 2018 the provider had not ensured staff received appropriate training to fulfil their role and agency workers had not received an induction. This was a breach of Regulation 18of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had implemented a 'mentoring system' to build staff's knowledge and skills. Coaching had been carried out in topics such as record keeping, medicines and choking. Permanent employees had received appropriate supervision and appraisal to support them to fulfil their role. A programme of training had also been implemented in areas such as mental health and autism to develop staff knowledge.

However, approximately 64% of the workforce consisted of agency care workers and care workers deployed from other services the provider owned. These staff had not received a robust induction, specialist training and did not understand the needs of the people they were asked to support. One member of staff told us, "We were not given any information about [Name of person] and how to support them." They did not know one person required two staff to support them with personal care and admitted there had been occasions where only one person had carried out this role. Other members of staff explained what their induction consisted of, "I was supported to have a walk through the service and shown where people's bedrooms were and I was shadowed doing the medicines." Staff from other homes and agency care workers were unaware of the number of people residing in the service, their needs around positive behaviour support, communication, nutrition, specialist diets, medical support and personal care needs.

The commercial director, regional operations manager and nominated individual explained how they had asked that each member of staff or agency care worker read the care plans in place. However, no check of staff's understanding or competence had been made by managers.

The impact of the lack of induction and monitoring of staff from other homes or agency workers meant people had received a poor service. For example, we observed staff not engaging with one person who had communication needs, because they did not understand them or how to intervene. Relatives shared their observations of the service and the poor outcomes for their family members. They said, "Agency don't know what to do, they have had no instructions, I don't blame them. Even [name of permanent staff member] had no guidance and knew nothing about my family member", "My relative is really struggling at the moment, they need encouragement from staff. We have told the staff to prompt them and if they don't then they become low and don't do things for themselves that they can." Another relative told us of an example of poor personal hygiene for their family member, because staff had not prompted the person or supported them properly.

People's quality of life and experience of using the service was inconsistent and was driven by the skill mix of staff on duty and their knowledge of people. On day one of the inspection staff did not know people well and the routine was busy and seemingly unorganised, staff did not know who they were supporting and how. On day two more experienced staff were on shift and the atmosphere was more calm and organised.

People had not received consistently effective support because staff did not have the training, support and skills required to fulfil their role. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the importance of a thorough induction, training and monitoring with the regional operations manager, commercial director and nominated individual. They understood for people to achieve good outcomes, a good quality of life and support to be based on good practice, this must happen. They agreed a programme of training, induction and mentoring of agency care workers and staff from other homes would start immediately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

Staff offered people choice and supported them to make their own decisions. Staff waited for consent before they supported people. One person said, "Yes they [staff] ask me if it is alright to support me with my medication for example." Records held in people's care plans were inconsistent around their capacity to make their own decisions. We discussed this with the regional operations manager who agreed to review records in relation to MCA and consent.

The regional operations manager told us three people had been authorised to be deprived of their liberty. One person's application had been denied and the provider was still waiting for other applications to be processed.

Some people had access to their own kitchen and others accessed the main kitchen and communal dining area. We observed most people still used the communal dining and kitchen facilities for their main meals and preferred to use their private facilities for snacks and drinks. Staff told us for one person their independence had increased with having their own kitchen area. We observed people choosing what they wanted to eat and when they wanted to eat. One person was supported to have a bacon sandwich after they had a relaxing bath and others helped to prepare their own lunch.

People told us the food was good overall. One person said, "The best thing about here is the nice food."

Each person had a nutritional risk assessment to determine if they were at risk of malnutrition. Some of these were incorrectly completed. The assessment determined how frequently a person should be weighed, but people were not always weighed at the right frequency. We looked at the support one person had received who it was felt was at risk of malnutrition. We saw they had been assessed by medical professionals to ensure staff were doing everything they could to support them. We therefore determined people were in receipt of the correct support but that records did not clearly identify this.

Since the last inspection lots of work has been completed to access medical support for people as they had not seen some professionals for some time. The detail received from professionals and the progress for each

person was not always recorded. For example, recommendations were made for one person around their mental health and these were not built into their support plan and the regional operations manager was not aware of the recommendations made. It was also difficult to determine which appointments had occurred and which were outstanding.

The service had seen some success supporting people to access appointments which traditionally they would refuse to attend. The commercial director explained they were trying to work with just one GP practice so they could build a relationship with them. For another person, reasonable adjustments had been negotiated to ensure the person successfully received a medical review. One person told us they were happy with the support they received for their healthcare. They said, "If I am poorly staff make an appointment. Someone is coming tomorrow to cut my toe nails."

The building has undergone a renovation over the past two years which is now complete. This has seen people have access to their own one room apartment or en-suite facilities. People told us they were happy with the work and were pleased it was completed.

Requires Improvement

Is the service caring?

Our findings

Lots of work has been done by the provider to ensure the staff on shift were as consistent as possible and that their approach was caring. However, the issues raised in other sections of this report regarding lack of induction for agency care workers and staff from other homes, and their lack of knowledge of people did affect people's experience of the care they received which was inconsistent in quality. For example, relatives told us their family members required support to maintain their independence and to develop new skills. We saw this had not happened.

Some people required specific support to communicate or staff required specific knowledge to understand people's communication. We saw staff were not skilled and therefore people were misunderstood or not listened to on some occasions. Work was needed to support staff to understand people's life histories, needs and preferences so that the full team of staff could develop meaningful relationships with people. This work was important for people who displayed behaviours that may challenge the service. Some of their anxiety was created because staff did not know how to communicate with them or understand their needs well.

Although staff did not know people's individual needs, they did approach people with compassion and respect. Staff knocked on people's doors and waited for permission to enter their room. Staff afforded people privacy when needed.

The approach of staff was observed to be caring and kind. People told us, "I like it here staff are kind" and "Staff are caring." One person who recently moved in said, "This place is definitely good. I like it here."

We observed people's demeanour to understand if they were comfortable and confident in their own home. One person had recently moved in and displayed no anxiety when staff approached them and was eager to show us around their room. They said, "I like it here." Other people were seen to be confident approaching staff for help and guidance. We also saw people enjoy a joke with the staff they knew.

Where staff had been employed for a longer period, we were able to see that positive relationships had developed with the people they supported. We observed one member of staff working with a person who had communication needs to help them convey what they wanted and to provide reassurance.

The regional operations manager had supported one person to be involved in developing their care plan through using large print text and affording them time to read and respond as they chose. The commercial director and regional operations manager had driven an approach for this person whereby consistent communication and support around medicines had seen them become more confident and taking their medicines more frequently. It was hoped this would improve the person's feelings of wellbeing. On this inspection we saw the person was more confident and happy to be part of the communal areas of the service. This is something they would not do in the past.

Two people told us they were keen to maintain their independence. They said, "I can do lots for myself and

staff just check I am ok" and "I am independent, just a bit of help to the shops." The service respected people's skills and supported to people to access the community independently and carry out their own household tasks such as washing their clothes.

An advocate was used by three people. For one person this was to help family and professionals understand if the service was the best place for them to live. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. The service was working with the advocate to ensure the person rights were upheld.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2018 we found it difficult to determine if people had received a responsive service which met their needs. This was because the records the provider used to monitor progress were not completed or used to review people's care. We also found that people did not have access to meaningful activities when supported by staff from the service.

At this inspection people still did not always receive responsive care and support. For example, care plans contained person-centred details, but staff did not know those details to provide care in the way each individual preferred. Staff did not know how to communicate with people or know about their mental health or medical needs., Because of this they were unable to focus the support they offered to ensure people's needs were met and preferences achieved.

One person required one to one support to enable them to access activities and to reduce social isolation. We observed staff offer this person an activity, but then wait sat with them for over an hour before they instigated engaging with the person. This meant they no longer wanted to go out and they missed an opportunity to access an activity because of staff lack of knowledge of them.

A relative told us, "My family member likes to be taken out each day. It doesn't happen there as they don't have the staff. They did try to get support for swimming, but it never came off." A visiting professional recorded in a letter following their input that they felt the environment and approach staff had did not promote social integration or successful outcomes for people. We asked one person what they did with their day and they said, "Not a lot watch TV."

Staff and managers did not use the records completed to understand if people were receiving the care they required. Monitoring records were not completed robustly. Where professionals had requested information be recorded, these were also not completed appropriately. Professionals told us this made it difficult for them to understand progress or make recommendations. Records did not always reflect that people or their relatives were involved in designing their own care and support or reviewing it.

A lack of person-centred approach, which focussed on each person's goals and aspirations meant people did not receive responsive care which met all their needs. This was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the commercial director, nominated individual and regional operations manager about the lack of person-centred care people received. They explained they were aware people showed little motivation to access the community or in-house activities. They had chosen specific staff from their other services to come and be role models for new staff to promote people joining more activities. A group activity planner had been instigated initially to get people used to different activities. They understood this needed to be more personalised, but wanted staff confidence to increase alongside people's motivation to join in.

This approach had started to be successful and people told us about trips to the seaside, local events and

upcoming events. One person said, "Me and [Name of person] went to Redcar in the minibus last week. We enjoyed the day out." The constant presence of the commercial director and regional operations manager had also meant people's confidence to accept some support had improved. For example, one person had accepted support from a GP, another person was more confident and they were now more compliant taking their prescribed medicines. For this person, staff had worked with them spending time to explain and reassure them.

People who had planned activities, day services or voluntary roles had been supported to maintain those links. One person regularly attended church and was an active part of their congregation.

Nobody required palliative care at the time we visited, however staff had recorded their wishes and preferences in some cases to ensure staff were aware when this was needed.

All the relatives felt confident raising concerns and had raised issues within the recent months to managers of the service. Although listened to and dealt with, none of their concerns were treated as complaints and we discussed this with the commercial director and new manager following the inspection. They felt they were working as closely as possible to make improvements when people raised concerns. We discussed recording them formally helps relatives or people feel listened to and reassured. They did instigate the complaints process following our conversation and provided us with a copy of their response to one relative.

People told us they felt confident raising concerns if they chose to. One person said, "I would see the 'big boss'. If I knew I was in the right, I wouldn't worry about complaining."

Inadequate

Is the service well-led?

Our findings

At the inspection in January 2018 the provider had not operated effective systems and processes to ensure people received high quality, person-centred and safe care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection the registered manager and key staff had left the service. This meant the provider had managed a crisis with regards to staffing and safety. Key senior managers from the provider had stepped in to provide a leadership presence each day and to work on improvements required.

The provider had implemented a series of audits to check progress, quality and safety. An action plan had been produced which highlighted most of the issues identified in this report. For example, poor record keeping, including health records and activities provision. The commercial director and regional operations manager had been asked to carry out the actions. Improvements had been made to the environment, medicines management and infection control because of this approach. The level of risk to people's safety had reduced since the last inspection although risks to their quality of life and health remained.

The provider had failed to recognise that agency care workers and workers from their other services had not received an appropriate induction. And that they did not know enough about people's needs to enable them to deliver person-centred effective support.

The provider had also failed to recognise that statutory notifications had not been submitted in relation to people's deprivation of liberty authorisations, as is required by law. When an application is approved or denied it is a legal requirement for the provider to send a statutory notification informing the CQC of the outcome. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is being dealt with outside of the inspection process.

The provider's leadership and management of the service had failed to ensure the overall rating had improved to Good for the fourth consecutive time. In addition, continued and new breaches of regulation were found at this inspection.

The leadership was therefore not effective enough to ensure people received high quality, person-centred and safe care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The commercial director and regional operations manager had worked to coach and mentor staff and the staff told us they felt listened to. Staff meetings had happened and were planned to ensure staff had the opportunity to raise concerns. People had also had the opportunity to attend a 'Service user meeting' where they could discuss day to day ideas or issues. We saw the minutes from April 2018 where people had been included in choosing the style of wall paper for the hallway and discussed places they may want to visit such as Scarborough. We saw such visits had happened.

A survey had been sent to people and their families and the provider told us they would review any feedback to implement changes to continuously make improvements to the service.

Some of the relatives had met the new manager who was due to start employment in July 2018. They told us they felt they were genuine and had listened to them. They hoped the new manager wold be a positive addition to the service and that improvements would be made because of their leadership. One relative said. "[Name of manager] was very sorry to hear my issues and explained they would work to make sure staff do what is needed." Another relative told us, "[Name of manager] listened and I feel we can work together."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and support based on their preferences to ensure their needs were met. Regulation 9 (1) (3) (a) (b) (c) (d) (e) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not have the skills, and competence to ensure people were cared for safely. Regulation 12 (1) (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process were not operated effectively enough to ensure people received high quality, person centred, and safe care. A complete and contemporaneous record of care delivered was not kept in relation to each person. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff including agency care workers had not

received an appropriate induction or training to enable them to fulfil their role.

Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of the outcome of deprivation of liberty applications.

The enforcement action we took:

We issued a fixed penalty notice.