Counticare Limited

Parkwood House

Inspection report

West Street
Harrietsham
Maidstone
Kent
ME17 1JZ
Tel: 01622 859710

Date of inspection visit: 18 December 2015
Date of publication: 18/03/2016

Ratings

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

Overall summary

The inspection was carried out on 18 December 2015 and was unannounced.

Parkwood House is a care home providing care and support for adults with learning disabilities. The service is registered to support 13 people. There were 9 people living at the service when we inspected.

There was a registered manager in place when we inspected, however, they had recently moved permanently to another service owned by the provider. An interim manager had been appointed whilst recruitment commenced for their replacement.

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.

People were not provided with activities which met their needs. People were not always actively involved in planning their meals. The quality assurance systems put in place by the provider were not being implemented and not effective in identifying areas for improvement.

Summary of findings

People were not safeguarded against abuse or the risk of abuse. Some staff were unclear on the signs to look for if they suspected abuse. Records showed that staff had received training in safeguarding vulnerable adults.

Staff had not received the training, support and supervision required to meet people's needs and fulfil their role.

People were not always offered a choice of meals in a way they could understand. People's food intake was recorded and action was taken if people's weight changed.

There were not enough skilled and competent staff to keep people safe and meet their needs. Staff were not adequately trained to meet assessed needs. A system was in place to assess the number of staff required however, the deployment of staff had not always been effective. The service had vacancies for care staff and used a high amount of agency workers to meet people's needs. The service was actively recruiting new staff. Recruitment practices were safe and checks were carried out to make sure staff were suitable to work with people who needed care and support.

People were treated with respect and staff knew how to maintain people's privacy and dignity.

People received their medicines safely and when they needed them. Policies and procedures were in place for the safe administration of medicines and staff had been trained to administer medicines safely.

People were not always offered a choice of activities to participate in.

People needs were assessed before moving into the service and care plans were reviewed on a regular basis, with appropriate changes being made when people's needs changed. People's health was monitored and when it was necessary, health care professionals were involved to make sure people remained as healthy as possible. Potential risks to people had been identified with steps recorded of how the risk could be reduced.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The registered manager understood their responsibilities under the Mental Capacity Act 2005 and DoLS. Mental capacity assessments and decisions made in people's best interest were recorded. At the time of the inspection the registered manager had applied for DoLS authorisations for the people living at the service.

Quality assurance systems had not been completed and not effective in recognising shortfalls in the service. Improvements had not been made in response to accidents and incidents to ensure people's safety and welfare. Incidents had not always been monitored, investigated with actions taken to minimise the risk of reoccurrence in line with the provider's policy.

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

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

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

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the report.

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?
The service was not safe.

People were not always protected from the risk of abuse. Some staff were not aware of their role or responsibilities in reporting concerns or abuse.

There were not always enough staff on duty to meet people's needs. Staff had not been effectively deployed based on their skills and experience.

Potential risks to people in their everyday lives had been assessed. However, individual risks to people had not been reviewed or investigated appropriately.

People received their medicines as prescribed by their GP.

Inadequate

Is the service effective?
The service was not always effective.

Staff had not received the training required to fulfil their role. Staff did not feel supported within their role.

People were not always offered a choice of meals in a way they could understand.

People's capacity to consent had been assessed and recorded in line with legislation.

People were supported to remain as healthy as possible.

Requires improvement

Is the service caring?
The service was not always caring.

People's choices and preferences were not always acted on.

Information and people's personal histories had been recorded.

People were treated with respect. Staff maintained people's privacy and dignity.

Requires improvement

Is the service responsive?
The service was not always responsive.

People were not supported to access a wide range of activities that was based on their individual likes and preferences

Care plans were reviewed on a regular basis and updated if they were required.

A complaints policy and procedure was in place.

Requires improvement

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

Systems in place were not used to monitor, assess and improve the quality of the service.

Incidents and accidents were not always reported, reviewed and investigated. Not all notifiable incidents had been reported to the local authority or the commission

There was a range of policies and procedure in place which the staff had access to.

There was a lack of leadership and management from both the provider and registered manager which had an impact on people living at the home.

Parkwood House

Detailed findings

Background to this inspection

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

This inspection took place on 18 December 2015 and was unannounced. The inspection team consisted of three inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had a background and understanding of learning disability services.

We gathered and reviewed information before the inspection including information we had received from a number of sources about the service.

We would normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks for some key information about the service, what the service does well and improvements they plan to make. However, this inspection was planned in response to concerns we had received and there was not time to expect the provider to complete this information and return it to us. We gathered the key information during the inspection process.

Some people living at the service did not use verbal communication; instead they used a mixture of sounds, gestures and signs. We made observations of interactions between people and staff. We spoke with the relatives of three people using the service to gain their views and experiences. We spoke with two care workers, the registered manager, the interim manager and the locality manager to gain information. We asked three health and social care professionals for their views.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at four people's care files, four staff record files, the staff training programme, the staff rota and medicine records.

A previous inspection took place on 29 September 2014 the service had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, in relation to complaints. At this inspection we found improvements had been made in this area.

Inadequate

Is the service safe?

Our findings

Relatives we spoke with felt their loved ones were safe living at the service. One relative told us that since the service had increased the security with a fence around the perimeter they felt their loved one was safe.

Observations showed that people appeared comfortable with other people and staff by smiling and giving eye contact. We observed one person speaking to staff about the Christmas tree being decorated, they were laughing and joking

Staffs knowledge and understanding of how to keep people safe varied. One member of staff was not able to describe any potential signs of abuse they would look for. Another member of staff described the signs they would look for. For example, bruising or a change in behaviour. Staff we spoke with said they would report any concerns to the manager or the provider. Staff had received e-learning training in safeguarding vulnerable adults. A member of staff we spoke with felt that the e-learning training in safeguarding was not sufficient. Staff we spoke with were aware of the provider's whistleblowing policy and procedure. Staff had access to the provider's safeguarding policy and procedure online. Incidents and accidents had not always been reported as a safeguarding concern. For example, one person had ingested half of a cleaning tablet which had not been reported to the local authority or the Commission.

People were not protected from abuse and improper treatment. This was a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not been effectively deployed to meet people's needs. For example, on the day of our inspection there were five staff on duty when we arrived at 9am. At 10am, three people were still in bed which we were told was their choice. A member of staff told us that one person prefers a male member of staff who had not been rostered on shift until 10am. The deputy manager told us that staff support people who are funded for one to one support first, and, then when they are free they support other people with their personal care needs. The locality manager told us that this was an error on the rota and it was not usual practice for the sixth member of staff to come in at 10am.

The service had current vacancies for care staff and had been recruiting to vacant posts. Records showed that there was a high use of agency staff and there had been a few occasions where the service had run short staffed. One member of staff told us that they "Managed as best they could" on days that there were not enough staff. The interim manager told us that two new members of staff had been recruited and were awaiting a start date. The service received profiles from the agency before they sent any staff to work at the service. The profiles included personal information about the agency worker and any training they had completed.

The locality manager told us that people had recently been assessed and the staffing ratio had been altered as a result. However, they agreed that the skill mix and experience of staff on duty was not always right. On the day of our inspection we observed a new member of staff supporting a person in the activities room. This member of staff required support and asked a member of the inspection team to alert another member of staff to support them. One member of staff told us that staff were not always matched with the appropriate people to meet their needs. At times staff lacked the skills and experience to support people with any behaviours that challenged. Records were not clear if people were receiving the one to one support they were being funded for. The service provided two staff who were awake and on duty throughout the night. Night checks of people were due to take place, however records were not kept up to date. We were unable to confirm if the checks had always been carried out.

The examples above are a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had up to date information to meet people's needs and to reduce risks. Potential risks to people, in their everyday lives, had been identified, such as risks relating to personal care, their health, communication and mobility. Each risk had been assessed in relation to the impact that it had on each person. Measures were in place to reduce risks and guidance was in place for staff to follow about the action they needed to take to protect people from harm. Risk assessments were kept under constant review and were updated if any changes were required.

People had a personal emergency evacuation plan (PEEP) and staff and people were involved in fire drills. A PEEP sets out the specific physical and communication requirements

Is the service safe?

that each person has to ensure that they can be safely evacuated from the service in the event of a fire. People's safety in the event of an emergency had been carefully considered and recorded.

Risks to the environment had been assessed and recorded. These included assessments for lifting loads, first aid box, security and visual display equipment (VDU). These assessments were for staffs reference and were regularly reviewed and recorded onto the provider's online system.

The premises were maintained and checked to help ensure the safety of people, staff and visitors. Procedures were in place for reporting repairs and records were kept of maintenance jobs. Records showed that portable electrical appliances, firefighting equipment and the fire panel were properly maintained and tested.

Regular checks were not always carried out on the fire alarm and emergency lighting to make sure it was in good working order in line with the provider's guidelines. These checks enabled people to live in a safe and adequately maintained environment. The fire risk assessment in place was dated December 2014, this had not been reviewed. People could not be assured that appropriate action had been taken to reduce the risk of a potential fire.

The provider had a process in place for any incidents or accidents. This included staff recording the details onto a paper copy of what had happened; this was then recorded onto an online system by the registered manager. Once the information had been recorded onto PSN the online system, the registered manager and the locality manager completed an investigation and documented any actions that had been taken. We looked at four incidents which had been recorded by staff within the accident folder. These were dated 12 June 2015, 29 November 2015, 3 December 2015 and the 10 December 2015. Only one of these incidents had been recorded onto PSN. The other three incidents had not been recorded and therefore the locality manager and the provider were unaware that these had taken place. Two of the incidents had involved staff being physically assaulted by people and the other involved the ingestion of half of a cleaning tablet. The locality manager confirmed that they were unaware of the incidents taking place. People had not been supported to remain safe within the service and action had not been taken to reduce the risk of reoccurrences. An incident had taken place which required investigation by the police and the local authority safeguarding team, the provider cooperated with the investigation as they had been requested to.

Incidents involving people had not always been reported, reviewed and investigated. This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices were safe and checks were carried out to make sure staff were suitable to work with people who needed care and support. Staff recruitment checks had been completed before staff started work at the service. These included obtaining suitable references, identity checks and completing a Disclosure and Baring Service (DBS) background check, checking employment histories and considering applicant's health to help ensure they were safe to work at the service. These processes minimised the risk of people receiving support from staff who could be unsafe to work with vulnerable people.

Medicines were managed safely. All medicines were stored securely and appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines. Clear records were kept of all medicine that had been administered. The records were clear and up to date and had no gaps showing all medicines had been signed for. Any unwanted medicines were disposed of safely. We saw that a lockable facility to store medicines was provided in each person's bedroom, which helped to promote people's independence. People were receiving their medicines as prescribed by the GP.

Clear guidance was in place for people who took medicines prescribed 'as and when required' (PRN). There was a written criteria for each person, in their care plan and within the medicine files, who needed 'when required' medicines. This gave people assurance that their medicine would be given when it was needed. Medicines audits were carried out on a daily basis by staff. We saw clear records of the checks that had taken place for non-blistered medicines. These checks minimised the risk of an error occurring.

Requires improvement

Is the service effective?

Our findings

People living at the service had complex health needs and some people were unable to communicate verbally so we made observations and spoke with the relatives of three people. One relative said their family member was cared for very well by the staff. Some of the staff knew people well including their personal histories, hobbies and interests. Some staff had worked at the service for a period of a few months. They had not been able to build up the same relationship with people as staff, who had worked at the service for a longer period of time.

New staff were expected to complete an induction at the providers head office which covered a range of mandatory courses. This included safeguarding vulnerable adults and the Mental Capacity Act 2005. This was then followed by a service specific induction. Two out of the five records we viewed showed staff had not completed this process. Two new members of staff who had worked at the service for a period of three months had not completed the mandatory induction course. Records showed that one member of staff who had not worked within the health and social care sector before had not completed training that the provider classed as mandatory. For example first aid, infection control and 'Maybo' physical intervention training. One member of staff told us that they had only completed training in epilepsy since joining the service three months ago. New staff worked alongside more experienced staff within the service before working unsupervised.

Records showed that there were gaps in the staff teams training. For example, first aid, infection control and physical intervention training. The interim manager told us that the training matrix was not fully up to date and he would need to go through it in detail. Staff completed training via e-learning with the addition of a distance learning course for medication. Not all staff had received up to date training to enable them to provide the care and support needed to meet peoples' needs.

Staff told us that they did not feel they had enough support from the management team through supervisions. These meetings provided opportunities for staff to discuss their performance, development and training needs. The registered manager told us that supervision meetings usually take place between 4-6 weeks, but some of the meetings had lapsed. The registered manager had carried out annual appraisals with staff to discuss and provide feedback on their performance, achievements and challenges faced over the past year.

Some people living in the service displayed behaviours that could challenge themselves and others. If people were required to be restrained by staff using 'Maybo' this had been developed in line with the Mental Capacity Act to ensure any restraint that took place was lawful. Records showed that no restraints had been recorded as taking place. Guidelines relating to managing and reducing behaviour that challenged had been prepared in consultation with a consultant clinical psychologist. The guidelines included strategies for staff to follow to reduce behaviour occurring and the action staff should take if behaviour occurred. Read and sign sheets were in place for staff to show the management team staff had read and understood these guidelines. However, records showed that not all staff had signed the guidelines to say that they had read and understood these. The interim manager and deputy manager told us they were aware not all of the staff had confirmed that had read the guidelines. They had planned to address this via a team meeting.

Only 11 out of 18 staff had completed the physical intervention training 'Maybo', not all staff had been appropriately trained to support people with any behaviours that may challenge. People may be at risk of receiving care and support that was not appropriate in managing any behaviours that may challenge as the staff were not appropriately trained.

Staff had not received appropriate training, support and supervision to carry out their role. This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff's knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005, and the Deprivation of Liberty Safeguards (DoLS) varied. For example, showing people pictures and items of reference to enable people to make a choice. Another member of staff told us that people living at the service were not supported to make decisions and that staff made the decision based on what they knew people liked. Not all staff had been trained to understand and use these in practice.

People's capacity to consent to care and support had been assessed. If people lacked capacity, the management team

Requires improvement

Is the service effective?

had followed the principles of the MCA and made sure that any decision was only made in the person's best interests. For example, a mental capacity assessment had been completed followed by a best interest meeting which involved a number of health care professionals regarding supporting someone with their health needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Some people living at the service were constantly supervised by staff to keep them safe. Because of this, the management team had applied to local authorities to grant DoLS authorisations.

People were not always offered a choice for their meals. For example, on the day of our inspection we observed a member of staff put a sausage roll on each of the 9 plates followed by a packet of crisps. People were not offered a choice of the flavour of crisps or an alternative to the sausage roll. A menu was available in the kitchen but this did not correspond with what people were given for lunch on the day of our inspection. Staff told us that people chose what they wanted for dinner and the service had started themed breakfasts such as croissants. One member of staff said about meal choices, "The verbal people can choose and the others have it chosen by the staff based on what they have had before." People were not always offered a choice in a way they could understand.

People were not provided with a choice regarding their food that met their needs. This was a breach of Regulation 9 (3) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of people's food intake had been kept with additional comments such as a memo to staff to monitor a person who appeared to have a reduced appetite. The kitchen was open and accessible to people living at the service. We observed people going into the kitchen to prepare and request drinks from staff. People were offered additional food if they were still hungry. For example, we observed staff asking people if they would like another croissant at breakfast. People chose where to eat their meals.

People we spoke with told us they could see a doctor when they needed to. People's health needs were recorded in detail in their individual care files. People's health was monitored and when it was necessary health care professionals were involved to make sure people remained as healthy as possible. All appointments with professionals such as doctors, district nurses, speech and language therapists, physiotherapist and chiropodists had been recorded with any outcome. Future appointments had been scheduled and there was evidence that people had regular health checks. People had been supported to remain as healthy as possible, and any changes in people's health were acted on quickly.

Each person had a 'My Keeping Healthy' care plan. This detailed how people wanted to be supported with day to day health care needs such as, oral hygiene, weight and continence. Specialist health care professionals had been contacted to support people with complex areas of the health care needs. For example, the Community Learning Disability Team had worked in partnership with the staff team to complete behavioural assessments for people.

Requires improvement

Is the service caring?

Our findings

One person responded, "Yes" when they were asked if they liked living at the service. Relatives told us that the staff were professional, hardworking and on the ball. A health care professional told us they had witnessed staff being caring towards people and that staff had a good rapport with people.

Information about people's preferences and personal histories had been included within their care plans. Staff told us that they felt the information within the care plans was limited. One member of staff told us they had taken people out for the day and found out new information about someone's history. They did not inform the management team to include the information within the persons care plan. Some of the staff on duty had worked at the service for over a year and knew people well. Staff were observed to be responsive to people's needs. For example, staff offered reassurance when someone was becoming anxious, this appeared to calm and reassure the person.

When people were at home they could choose whether they wanted to spend time in the communal areas or time in the privacy of their bedroom. We observed people choosing to watch television in the lounge and spend time in their bedroom which was respected by staff. People could have visitors when they wanted to and there were no restrictions on what times visitors could call. People were supported to have as much contact with their friends and family as they wanted to.

People if they were able to were involved in developing their care plans. People who had complex health needs had family and health care professional involvement in the development of their care plans. Within each person's care file included a section named 'Things you should know about me', this included detailed information about people's likes, dislikes and what was important to them.

People were involved in regular house meetings. These gave people the opportunity to make suggestions about the service. Other topics of discussion included what people should do if they were unhappy, staffing and activity suggestions. Records showed that during the meeting in October 2015 people said they would like to attend a pantomime and see Father Christmas. The registered manager told us that this had not been actioned prior to our inspection in December 2015. People were given the opportunity to make suggestions and improvements about their lives and the service they live in, although these were not always acted on. The registered manager told us that they had not had an opportunity to arrange this.

People's preferences, choices and requests were not always acted on. This was a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection people were treated with respect and that the staff took appropriate action to protect people's privacy and dignity. Staff explained how they supported people with their personal care whilst maintaining their privacy and dignity. People, if they needed it, were given support with washing and dressing in privacy. We observed staff knocking on bedroom doors and waiting for a response before entering. People's bedrooms were personalised with photographs of people who were important to them and their interests. People had equipment like televisions, radios and music systems.

Records were held securely and located quickly within the office.

Requires improvement

Is the service responsive?

Our findings

Observations showed that people did not always receive the care and support that they needed when they wanted it. For example, one person was in bed awaiting support from a male support worker on the day of our inspection.

Staff were observant when they were around people and noted when people appeared to be unhappy or feeling anxious. For example, staff spoke to a person who had appeared to become anxious. Relatives told us that there had been a lack of communication over the past year. One relative spoke about their loved one previously having a communication aid which had helped but this had not been used over the past year.

People had individualised 'Pen Profiles' which included information for staff in how to promote family contact and clear guidance on people's preferred activities. Activity choices included TV programmes, musical instruments, swimming, arts and crafts and bowling. On the day of our inspection some people were supported to go out bowling after lunch. This activity had not been well organised by the staff and people were waiting for a period of two hours with their coats on before they actually left the service for the activity. A member of staff told us they would need to be back at the service before their shift finished at 16.30pm, this meant people were restricted with the amount of time they could access the community. Relatives we spoke with had raised concerns about the lack and choice of activities people participated in. People were not always offered a choice or the choice was limited in any activities to participate in. Activities were not always based around people's interests. A relative told us previously their loved one had participated in a number of activities they enjoyed.

The provider failed to provide activities to meet people's individual needs was a breach of Regulation 9 (1) (a), (b), (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were reviewed on a regular basis, changes were made when support needs changed, to ensure staff were following up to date guidance. Some people were not able to communicate using speech and used body language, signs and facial expressions to let staff know how they were feeling. Staff understood people's communication needs and interpreted what people wanted and what people were saying. People with complex communication needs had detailed individualised communication plans within their care plans. These included guidance for staff under the following headings, When, Who, What, Meaning and Response. We observed staff communicating with people with their preferred method of communication. For example, one person chose to be called by a different name and this was actioned by staff.

People were assessed before moving into the service. The assessment included a screening process to ensure suitability, visits to the service to meet other people living there and an assessment of people's needs. The process reflected the policy and guidance on assessments and admissions.

The provider had a complaints policy and procedure in place which was available to people and given to relatives. This included the procedure people could follow if they were not happy with the complaint response. Relatives we spoke with were confident that any complaints they raised would be listened to and acted upon. There had been a complaint made since the last inspection regarding missing laundry from a relative. A formal procedure was followed. The locality manager had responded to the complaint following the policy with all contact and actions fully recorded.

The service also kept compliments which had been received from relatives, these included information from a relative which read "We would like to say a big thanks to everyone for taking such good care of him and allowing him to enjoy many new life experiences." The provider sent out annual surveys to family and friends to gain their views and feedback. Records we saw related to the previous manager of the service and were complimentary. Feedback from this year's annual survey was not made available to us. Relatives we spoke with gave us mixed views about the service, one relative told us they were overall happy with the service provided, and another said that they felt things have gone array badly over the past year. There had been a number of changes in management which had had an impact on the people living at the service.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in place that was no longer in day to day management of the service. The registered manager had moved to manage another one of the provider's services. An interim manager had been appointed by the provider whilst a new registered manager was recruited. The registered manager, interim manager and locality manager were available throughout our inspection.

Staff we spoke with felt there was an open culture at times within the service but at times they felt things were "Hush hush". Staff told us there had not been visible management and leadership within the service, but they were hoping this would now change with the interim manager. Staff told us they were asked to contribute ideas about the service. Relative's told us that communication with the management team had reduced over the past year. Following a serious incident the registered manager had not acted appropriately to support the staff. Records showed that a member of staff had been advised to act as if it was a normal day, however the registered manager had recorded that they were available if they wanted to talk. The provider did offer staff external counselling contacts as an interim support measure. The registered manager had not provided staff with the support and guidance they required, they told us that some things had lapsed recently. The registered manager had not completed any quality monitoring of the service. These checks would have highlighted the shortfalls that we found during our inspection. For example, incidents had not been reported to the local authority safeguarding team.

The registered manager had not offered support the staff. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality assurance systems were in place, but these had not been implemented or consistently maintained by the registered manager or the provider. The quality assurance file included sections for the following audits medication, health and safety, the kitchen, my plans, infection control and the service improvement plan and contract monitoring visits. All of these sections were empty; when asked the registered manager told us, "They had not kept on top of the quality assurance systems." The provider visits did not have anything recorded since 2013 and the service audits/ quality performance monitoring had no records since 2012. Systems in place had not been completed to regularly assess, monitor and improve the quality of the service being provided.

The provider did not have effective systems in place to assess, monitor and improve the quality of the service being provided to people. This was a breach of Regulation 17 (1) (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager had been in post at the service for three days. They had worked for the provider for a period of 15 years and had experience managing services supporting people with complex health needs. The locality manager told us that the interim manager would stay and support the new manager once they had been appointed. An action plan had been developed which had highlighted the areas of concern within the service following a recent safeguarding concern. The interim manager discussed the challenges they felt were a priority that they had seen since joining the service and how they would improve outcomes for people.

The registered manager understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, if a person had died or had had an accident. All notifiable incidents had been reported correctly and in a timely manner. The registered manager and the interim manager told us that they felt support in their role by the locality manager.

There were a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed. Care records were up to date, held securely and were located quickly when needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 **Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **People were not protected from the risk of abuse by receiving support from staff who had not been trained and supported.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Staff had not been effectively deployed to meet people's needs. Staff had not received appropriate support, supervision and training to carry out their role.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Incidents involving people had not always been reported, reviewed and investigated.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Systems to assess, monitor and improve the quality of the service had not been implemented.
	Regulation 9 (1) (a) (b) (c) (3) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 People's choices and preferences were not always acted on. People were not offered activities to meet their needs. People were not offered food choices to meet their needs.