Parkcare Homes (No.2) Limited

Devon House

Inspection report

49 Bramley Road
London
N14 4HA

Tel: 02084470642
Website: www.craegmoor.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

Devon House is a care home registered to provide accommodation, nursing and personal care for up to 11 people. The service supports people with an acquired brain injury, many of whom had complex physical health conditions. Some people also have additional mental health needs.

At the time of our inspection there were nine people living in the home, and one person was admitted for a short respite stay over the period of the inspection.

Why we inspected:

The inspection took place following notification of a serious incident in April 2019 in which a person using the service died.

People's experience of using this service:

We found serious concerns regarding the governance of the service since the last inspection. The provider's audits did not find all the areas of concern this inspection highlighted. We found even when the provider's audits had identified areas of concern, action to make improvements had not always taken place, or been effective.

Whilst there were care plans in place for people, they lacked important detailed information regarding people's health needs and how to meet them.

Risk assessments did not provide staff with detailed guidance to meet people's needs safely in many areas including moving and handling, managing epilepsy and diabetes.

Staff were not provided with suitable support to carry out their role as there were low levels of supervision and lack of training in key areas. There was lack of consistent clinical leadership at the service as the provider had not adequately covered this role when a key member of staff was seconded to another service.

People who could communicate told us they liked living at the service and staff were kind and caring. People's relatives and health and social care colleagues confirmed this was the case.

There were activities at the service which people enjoyed, and people spoke well of the food.

We saw residents' meetings took place regularly so people's views were considered in the running of the service.

Rating at this inspection and follow up:

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures 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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report. However, full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Further inspections will be planned for future dates.

Rating at last inspection:

At the last inspection on 8 May 2018 the service was rated Good; the last report was published on 12 July 2018.

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.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was caring.

Details are in our Caring findings below.

Good

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-led findings below.

Inadequate

Devon House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident in April 2019 following which a person using the service died. This incident is subject to investigation by other parties and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk in caring for people at the service. This inspection initially looked at Safe and Well-Led domains on 15 April 2019. However, we extended the scope to become a full comprehensive inspection, covering all five domains of the service to ensure we inspected all areas of care at the service. We visited the service on 23 April 2019 to complete the comprehensive inspection.

Inspection team:
The inspection team consisted of two adult social care inspectors, a specialist advisor nurse 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 home.

Service and service type:
The service provides care to people with an acquired brain injury, some of whom have mental health needs. The majority of whom are under 65.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced on both days.

What we did:
Before the inspection, we reviewed information we held about the service, including previous reports and notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We also spoke with the local authority regarding the incident which prompted this inspection to get a picture of current concerns.

As part of the inspection process:
We spoke with the registered manager, deputy manager and two operational directors. We also spoke with four support workers, two members of nursing staff, the chef and the activities co-ordinator. We also spoke briefly with additional support staff the provider had temporarily placed at the building who were updating care documentation and reviewing information for staff.

We also spoke with six people who used the service and two relatives whilst at the service, as well as one visiting health professional.

We looked at seven people's care records, medicine administration records (MAR) and medicines management. We looked at records of accidents, incidents and complaints, records of residents' and staff meetings. We looked at three staff recruitment records and training and supervision for the staff team. We looked at audits and quality assurance reports.

We asked for feedback from six health and social care professionals about the service, and heard back from four in addition to the health professional we spoke with on the day. We also spoke with three relatives on the phone following the inspection visits.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● People living at the service had complex physical conditions as well as an acquired brain injury. We were concerned there was a lack of risk assessments in place for key areas of risk including the management of epilepsy, stoma care, catheter care and tissue viability. Whilst there was some information available on care records, it was not always easy to find or available for all staff. For example, there was some information regarding moving and handling embedded in care plans, but there were no detailed moving and handling risk assessments to provide detailed guidance for staff.

● Despite two people being prescribed emergency medicine for the management of epilepsy there was no risk assessment to provide personalised guidance to staff. One member of care staff was not aware anyone at the service had epilepsy. The lack of detailed, personalised information in the management of risks associated with complex medical conditions placed people at risk of receiving unsafe or poor care.

● We noted on the first day of the inspection that one person had contradictory information on care records between the guidance from the GP and that of the care plan, regarding the angle at which they were to be supported when being fed through a PEG system. This is a medical procedure in which a tube is passed into a patient's stomach through the abdominal wall. This is usually used as a means of feeding when oral intake is not adequate or not safe. We raised this as an issue of concern. We checked on the second day of the inspection if this contradiction had been resolved. It had not. This placed the person at serious risk of aspiration. Following our discussion with the incoming operational director on day two of the inspection, the issue was addressed.

● Following a serious incident in April 2019 at the service, people's ability to swallow and eat safely was reassessed by Speech and Language Therapists (SALT). However, we noted that one person who required a pureed diet and thickener for fluids also indicated in their 'keeping hopeful plan' that they liked to shop for food and go out for meals. There was no guidance for staff in how to support this person in these activities, given their interests and how their dietary requirements affected this. The lack of a risk assessment in relation to eating out and buying food out placed this person at serious risk of harm. This issue was raised on the first day of the inspection as a concern. We checked on the second day of the inspection that this risk had been addressed. It had not. When we raised this with the incoming operational director, they acted to stop this person going out shopping or eating out until further guidance was sought from SALT staff.

● People who had behaviours that challenge or diagnosed mental health needs did not always have sufficiently detailed risk assessments in place to minimise their risk of harm and to provide guidance to staff in how to manage these behaviours.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The service appeared clean and there was protective clothing for staff to use to prevent the spread of infection. However, despite an internal audit at the end of February 2019 highlighting problems with the fridge temperature, we found on the first day of the inspection the service had not taken remedial action to ensure the equipment was working effectively and food was stored within safe temperatures. This placed people at risk of harm.

The above concern was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● By the second day of the inspection the service was no longer using one fridge, with another fridge ordered and the other fridge had a new temperature probe which showed temperatures were within safe limits.

Using medicines safely

● We inspected medicines on the first day of the inspection. Overall, we found medicines were managed consistently and safely in line with national guidance.

● Medicines were stored safely and were administered by staff who had received the relevant training and we saw permanently employed staff were assessed annually for medicines competency.

●Staff followed the guidance in place on managing 'when required' medicines for each person and documented the reasons why they had administered the medicines.

●However, we found one gap in the MAR chart where a medicine was signed for, but it was still in the blister pack.

● We also noted that audits undertaken did not show running balances of stocks including stocks carried forward each month. This meant it was difficult to accurately keep track of stocks of medicines. The registered manager told us they would ensure this was changed.

●During the period of the week in which the inspection took place, a local authority professional audited medicines and found issues with a gap in MAR, which showed that a transdermal pain relief patch had been replaced after 48 hours rather than 72 hours.

Staffing and recruitment

● Staff recruitment was safe. Appropriate criminal records checks and references were completed prior to staff starting work. This meant staff were considered safe to work with vulnerable people.

●Staffing levels were evaluated depending on need and had been recently increased to enable staff to attend meetings as necessary following the incident.

●Agency staff were regularly used by the service. We saw the service used one main agency to maximise continuity of staff, although on occasion nursing staff unfamiliar with the service were employed. This was of concern as outside of office hours the nurse in charge also provided overall management of the service. There was no protocol or condition in place to stipulate nursing staff needed to have experience of the service to also undertake this role.

Systems and processes to safeguard people from the risk of abuse

● The service had notified CQC and the local authority of incidents that had occurred since the last inspection. There were systems and processes in place to safeguard people from risk of abuse and staff were able to tell us the different types of abuse and what they would do if concerned.

●The service kept a log of safeguarding incidents with actions taken. However, it was not always clear that lessons were learnt and information shared across the team to minimise future re-occurrence.

Accidents and incidents

●The provider had a computer-based system which staff completed following an incident. Although we could see accidents and incidents were recorded and remedial action taken at the time, it was not always evident that there was broader learning shared across the team to minimise the risk of re-occurrence.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

● We had concerns that the provider and registered manager were not effectively supporting and training staff to ensure they had the appropriate skills, knowledge and clinical support for their role.

● For example, following the last inspection in May 2018, monthly supervision rates fell to as low as 9%, 12% and 15%. Compliance rates increased for some months, including in January and February 2019. However, despite the provider being aware of the low levels of supervision from November 2018 remedial action was not taken on a consistent basis, with December 2018 and March 2019 having two of the lowest compliance levels.

● We found there was no written records of supervision for either the deputy manager or registered manager since the last inspection. This was important as both the deputy manager and registered manager had taken on new roles for part of the period following the last inspection. Whilst they had 'catch up' calls with their respective managers there was no formal record of discussions that took place or actions agreed.

● Although an induction took place for both agency and permanent staff there was no evidence that the skills of nursing staff were evaluated by the service to ensure they could meet the specific needs of the people at the service.

● For example, nursing staff at the service were from a range of disciplines including general nursing, mental health and learning disability. We found medicines competency assessments had been completed in the last 12 months for permanent and bank staff employed by the service. However, there were no other competency checks undertaken of nursing staff to show that they could safely provide practical nursing tasks to people including catheter care; stoma care and the giving of rectal medicine for two people prescribed on an 'as needed' basis.

● It was important that nursing staff competency was checked by the service as there was only one nurse on shift at any time so they were responsible for all nursing tasks on their shift.

● Although there were posters on the wall related to the generic care of people with epilepsy, there was no evidence that epilepsy training had taken place for all staff.

● Since the last inspection there had not been consistent full-time clinical leadership at the service. We were told by staff, "I think this is a good home, but it would have benefited from more clinical leadership." Two health and social care professionals noted the sporadic clinical leadership at the service in the period since the last CQC inspection. All health and social care professionals noted the commitment of the staff to providing good care.

●These concerns are addressed further in the Well-led section of the report

● On the second day of the inspection we were made aware that the registered manager was booking training courses in the following areas: epilepsy training, catheter care, dysphagia, oral health, basic life support and a continence skills refresher course. To minimise harm to people in the interim period, the

registered manager told us they would hold a short learning session to ensure staff were aware of the important issues to meet people's needs.

Supporting people to live healthier lives, access healthcare services and support;
● Lack of suitable care plans and risk assessments related to specific health conditions meant we could not be confident that people's health needs were met safely in line with best practice. This also meant the provider could not be confident that people's health needs were being safely met.
● For example, even though people were at risk of skin break down and had tissue viability risks due to their health conditions we found on the first day of the inspection people's Waterlow assessments, which are used to gauge risk of skin breakdown, had not been updated and reviewed on a regular basis. By the second day of the inspection new Waterlow assessments had been completed.
● On the first day of the inspection we found there was no turning chart or similar in place for staff to check people did not lay in one place for too long a period which increased the risk of pressure areas developing. By the second day one turning chart had been installed and we were told a second was planned to be put in place for another person.
● Despite two people having insulin dependent diabetes at the service there was only a care plan with personalised information in the MAR chart for one person. This information was not available to all care staff as only registered nurses routinely looked at the MAR. For the second person there was no care plan for this health condition at the service. This meant that we were not confident that this health need was met. The registered manager acknowledged this placed people at risk of harm.
● We asked how staff ensured one person who required a catheter change had this attended to regularly. There was no detailed care plan to stipulate how often this was to be changed and the stickers to evidence the catheter had been changed were not retained after 31 December 2018. We asked the registered manager how they would know the catheter had been changed and they reported it would be recorded in the daily notes, but they acknowledged that they were not able to confirm when it was last changed, prior to the catheter change taking place on the first day of the inspection.
● This was evidence of a lack of effective systems to monitor that good health care was provided by nursing staff.
● We found one person, who had exercises for their hands and feet set out by a health professional. did not have a care plan or routine for these to take place. They were important as this person required good dexterity of their hands to use a computer tablet to assist with communication. The registered manager checked the daily records from the end of February 2019 and could only find four entries to show the exercises had taken place. Not all stipulated the foot exercises had been completed. This showed a lack of person-centred health care for this person.

Staff working with other agencies to provide consistent, effective, timely care
● Health professionals told us staff worked co-operatively with their agency and we could see that referrals for services were made to other organisations. We were told staff followed care instructions provided by other health professionals.
● It was not always clear if rehabilitation services were available to promote continued improvements in health, communication and mobility, despite people having complex conditions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We found one person's assessment for a permanent placement was detailed and addressed a wide range of areas of need. Another person's pre-assessment documentation for respite was lacking in detail as it did not address their mental capacity or provide detail on their moving and handling needs despite being a wheelchair user.
● We discussed the lack of information gathered for this person with the registered manager who told us the

commissioners were unable to provide further information. They acknowledged this potentially put this person at risk of harm. We were concerned the service had not used the respite period as an opportunity to record their needs in more detail so this information was available for staff during their next period of respite.

Ensuring consent to care and treatment in line with law and guidance

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The service used a tracking system to record DoLS applied for; those authorised and their date of renewal. However, the registered manager did not have a system to record any conditions associated with the specific DoLS for individuals.

● Staff we spoke with understood the importance of consent, however the provider's internal audit found the nursing staff interviewed did not all have an adequate level of knowledge of the MCA, best interests decisions or Deprivation of Liberty Safeguards. The provider audit found they were not able to confidently give examples of how this legislation may apply to the service users they cared for. The registered manager told us they planned further training in this area.

● On the first day of the inspection we found not all MCA assessments had been reviewed in the last 12 months. By the second day of the inspection we found that the majority of these had been updated.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they enjoyed the food and we saw that discussions regarding the menu were held at each residents' meeting.

● People spoke well of the chef and their flexibility to meet people's choices for food.

● Some people were fed via a PEG tube. We found records for these were kept and sufficient information and guidance was in place for staff.

Adapting service, design, decoration to meet people's needs

● The service was in a large building, on two floors. There was a lift to the second floor. The garden was accessible to people living at the service and there was a large patio for their use.

● The kitchen was due for renovation and there were plans for this to take place within the next three months.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

● People told us permanent staff were kind and caring and we saw this was the case during our inspection. One person told us the night staff were not always as caring as the day staff. During the day we saw staff were patient and compassionate even when faced with challenging situations.

● Health and social care staff also told us they saw staff were kind and caring, and relatives confirmed permanent staff were kind and caring. One relative said, "Staff are exceptionally kind, they respect and care for my [relative]'' another told us "Yes, staff are very kind and caring."

● Staff were able to explain how they met people's religious and cultural needs. One person was supported to the mosque when they chose to attend, and Halal meat was available.

● For other people attendance at church or other religious places of worship was important and people were supported to meet these needs.

Supporting people to express their views and be involved in making decisions about their care

● It was not always clear that people were involved in care planning at the service as care documents were not always signed. For some people this may not have been physically possible, but this was not recorded. Three people told us they had heard of their care plans but could not tell us anymore. Some care plans had been signed by relatives on people's behalf.

● We saw that there were regular residents' meetings and this showed people were asked for their views on activities, menus and whether they were happy with the care provided.

● Care records reminded staff to wait patiently for people to respond and offer them choices.

Respecting and promoting people's privacy, dignity and independence

● Staff could tell us how they ensured people had privacy and were treated with dignity. For example, by shutting doors, talking with people respectfully and covering up people.

● However, we witnessed three occasions when people were provided with care without full privacy. On one occasion a person's door was open when staff were providing care and we saw one person's PEG flushed on two occasions on the same day when they were in the living room, in view of other people. We discussed this with the registered manager who was surprised and told us they would address this issue.

●Relatives told us they saw staff treating people with dignity and respect. People told us they were happy at the service.

●We could see that people were encouraged to participate in activities and develop communication skills. One person was improving their travel skills with the goal of using the local bus themselves. In this way we could see staff were promoting people's independence. But it was not always clear from care records what people could do for themselves in relation to personal care or other activities of daily living.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs
Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● The service set out care plans under the headings 'Keeping healthy, keeping safe, keeping connected, keeping well and keeping hopeful'. These had been completed or updated in the last 12 months and gave useful information for staff regarding people's overall needs. For example, stating if people were continent, had personal care needs, if they had issues with eating and drinking, communication needs and generalised information regarding moving and handling. Care plans gave personalised information regarding people's interests, although they lacked detail regarding routines and did not always indicate likes and dislikes.
● Care plans lacked specific detail in relation to key areas of information regarding people's physical and mental health medical needs as outlined in the Effective domain.
● We also found whilst some had background information on people which told staff about their lives prior to their brain injury, and important family members, others did not. This was important as some people were unable to communicate verbally.
● Information regarding people's needs was held on paper records as well as on the computer system. We found that whilst some care records had been updated on the computer system, paper copies had not always been so. Agency staff did not always have easy access to the computer records, so they did not always have access to the latest versions of care records.
● At the time of the inspection there were six easy read care records in place which were available for staff which outlined in broad terms people's needs. The service told us they had plans to put additional easy read care plans to assist agency staff in understanding quickly people's needs. We were told the service planned to complete these for all the people at the service.
● Information was on care records regarding people's hobbies and activities they liked to do. People told us activities took place and this was confirmed by relatives.
● We saw activities were discussed at residents' meetings. One relative told us staff were, "Very engaged" with their family member and really thought "about their quality of life". They gave us examples of the service supporting this person to access music in a way that was very positive for them.
●The service ensured that care staff helped with activities which expanded the options for people available. This usually worked well unless the service was short of staff when this impacted on activities.
●There was a van available for people to go out in with a driver available three days per week. People enjoyed going out and we could see regular trips were made to various markets and cafes.

Improving care quality in response to complaints or concerns
● The service had a complaints policy and procedure in place. The registered manager told us there was one complaint logged on the system since the last inspection. We asked the registered manager how day to day concerns were addressed and they told us they dealt with them at the time but did not log these. This meant they could not see if there were patterns to issues arising.
● People's relatives told us they found the registered manager and deputy responsive, but we found one complaint from August 2018 had not been dealt with as it had been overlooked. We also found that there

was no system to collate compliments. Services can learn from feedback from compliments and compliments about their service.

● Following the inspection the service had put in place a system to log day to day concerns and committed to addressing the outstanding complaint.

End of life care and support

● The service had an end of life policy but had not had any end of life discussions with people. Following the inspection, we could see from the service improvement plan this was added as a task, but without a target date.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- We found serious concerns with the quality of care at the service which indicated a lack of understanding of quality performance at both a provider and service level.
- We also had concerns that the registered manager, operational director for the service and the provider's quality assurance team did not understand and assess risks to the service since the last inspection in May 2018. This meant that there were changes in the day to day management of the service without risk mitigation to ensure people's clinical needs continued to be met.
- At the last inspection, at which the service was rated as 'Good', we were made aware that the previous registered manager was not providing day to day management at the service. This was provided by the service manager who had provided good leadership at the service in the period prior to the last inspection.
- At this inspection we were made aware that the day following the last CQC inspection the service manager had been asked to support other services run by the provider. Consequently, there were long periods between May and December 2018 when there was significantly reduced clinical leadership at the service.
- From 5 December 2018, the service manager became registered with the CQC as the registered manager of Devon House, but was then seconded to another service full time for a period until the middle of March 2019.
- The registered manager had not formally returned to the service until the day of the CQC inspection, although they had visited the service following the incident to offer support and guidance.
- Since the last inspection in May 2018, the day to day management of the service had rested largely with a staff member, who whilst well regarded by staff did not have clinical experience. This shortfall was not appropriately filled by the provider.
- Whilst some audits were taking place at the service, effective remedial action was not taken by either the registered manager or senior managers. For example, gaps in monthly reviews of care plans, risk assessments and malnutrition review tools for some people were evident from June 2018 and this continued up until this inspection. Despite the service improvement plan (SIP) in November 2018 highlighting low levels of supervision, this continued to be a problem throughout the period from May 2018 to this inspection. This has contributed to a lack of quality measures in place at the service.
- The SIP on 8 March 2019 noted "Clinical Governance process are not embedded on site which could result in a lack of oversight of quality improvements and lessons learned on site." Clinical governance meetings were not taking place every month as required and did not show actions followed up or always acted on.
- An internal health and safety audit focusing on the kitchen in February 2019 found the service to be inadequate. One of the areas of concern was the temperature of the fridge for storing food. At the first day of

our inspection, over six weeks later we found the temperature of the fridges was not at safe levels consistently throughout the day.
● These examples illustrate that despite senior managers being aware of issues of concern in a number of areas there was little effective action to remedy concerns. This was evidence that the provider did not effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, at the service.
● Whilst there were care plans in place which contained some person-centred information, the lack of detailed health care plans placed people at risk of significant harm.
● The service employed staff from a range of nursing and care backgrounds. People living at the service had a combination of complex physical and mental health needs. We found since the last inspection the service had admitted additional people to the service with very high levels of care needs.
● However, the provider and registered manager did not evaluate individual staff member's nursing skills to ensure that they were capable of providing high quality care and support to individual people. In this way they were not assessing, monitoring and mitigating the risks related to the health, safety and welfare of people using the service.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the serious incident in April 2019 there has been significant additional management support at the service to improve care records. A service improvement plan has been updated to address concerns identified by the inspection, other visiting health professionals and the provider.
● We were concerned that some issues of risk identified on day one of the inspection were not addressed by day two of the inspection despite there being a week in the intervening period. However, an incoming operational director ensured the highest risk issues were addressed on the second day of the inspection.
● Since the last inspection the service has notified CQC and other agencies of significant and safeguarding events that have either taken place or are alleged to have occurred, as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We saw that meetings for people who lived at the service took place, however, staff meeting minutes were not available for the period May – November 2018. This meant we could not see whether lessons from incidents were shared across the team, or best practice issues were discussed. Three staff meetings had taken place from 31 December 2018 until this inspection.
● Staff spoke well of the registered manager and deputy of the service. Health professionals noted the leadership qualities of the registered manager at the service but also that due to commitments at other services they were not always available.
● There had not been a survey of people's views since that undertaken in January 2018.
● Since the last inspection there had not been any relatives' meetings. Family members told us that the service communicated with them regarding issues that arose with their relative.

Continuous learning and improving care
● In May 2018 the CQC inspection rated the service 'Good'. We noted the achievements of the service manager in improving the service. At this inspection it was clear the improvements made in May 2018 were not consolidated at the service by the provider. Instead the service manager, who later became the registered manager, was moved for substantial periods of time to support other services run by the provider.

● From May 2015 until May 2018, there had been four comprehensive inspection and one focused inspection

all of which were rated 'Requires Improvement'. During this period CQC also issued two Warning Notices. The decline in care standards found at this inspection showed us a lack of commitment by the provider to embed the good practice found at the May 2018 inspection.

● At the time of the inspection in May 2018 the provider was implementing the introduction of computer based care planning system. The aim of this was to provide staff with easy access to care information which could be updated. At this inspection we found the computer based care planning system had not been fully implemented. Instead information regarding people's needs was stored in a number of places, for example, the clinical room, paper based and on the computer, which meant it was not readily available for staff.

● As referred to in the Safe domain, there was not always evidence of the service learning from incidents, accidents or safeguarding concerns.

● The above are examples of a lack of continuous learning and improvement of care by the provider.

Working in partnership with others

●Health professionals told us the service worked well in partnership with them and made referrals to other professionals when staff identified issues of concern.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess and mitigate all the risks to the health and safety of service users of receiving the care or treatment. The provider did not act assess the risk of, and preventing, detecting and controlling the spread of, infections including those that are health care associated. Regulation 12(1)(2)(a)(b)(h)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not assess, monitor and mitigate all the risks to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

Issued a Warning Notice