Aspire Specialist Care Limited

Saint Josephs Specialist Care Home

Inspection report

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Ratings

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

Overall summary

We completed an unannounced inspection of Saint Josephs Specialist Care Home on 11 May 2015. We had previously inspected the service in January 2015, where we found breaches in the regulations for people's care and welfare, assessing and monitoring the quality of service provision, safeguarding people and providing sufficient staffing to meet people's needs. We took enforcement action and issued warning notices in respect of these regulations. We also found breaches in the regulations relating to the safe use and management of medicines, people's consent to care and treatment, record keeping, recruitment practices and supporting staff. We made compliance actions against these regulations and at this inspection. At this inspection we found the improvements we required had not been made.

Saint Josephs Specialist Care Home is required to have a registered manager. At the time of our inspection in May 2015 there was no registered manager in place. The former registered manager had left the service on 22 March 2015. A registered manager is a person who has

Summary of findings

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.

Saint Josephs Specialist Care Home is a care home for up to seven younger adults with learning disabilities or autistic spectrum disorder who require specialised care and support. At the time of our inspection five people were supported to live at the service. People using the service had a range of complex needs in relation to their communication and behaviour.

At this inspection we found inappropriate physical restraint practices and other restrictions were used and had not been detailed in people's care plans or risk assessments. Appropriate safeguarding processes had not been followed and the provider's responses to deal with allegations had not protected people from the risk of abuse.

Staff did not know the best way to keep people safe should an emergency evacuation of the building be required. The procedure introduced for staff to identify what area of the building had an activated fire alarm was unsafe and inappropriate. The premises, fixtures and fittings required repair and the provider was not clear when this was going to happen.

The provider's staff recruitment processes did not ensure staff were safe and suitable to work with the people living at the home. The provider also failed to deploy sufficient numbers of staff to meet people's needs in a safe way.

Storage of medicines was not adequate as the security of the storage had been compromised through a damaged door. Medicine audits were not effective and medicines that should have been returned to the pharmacy had not been identified. Guidance to ensure people received medicines that they needed, 'as and when required,' were not in place. We were not always able to tell if people had received their medicines as prescribed because of recording errors.

Staff did not have adequate knowledge of people's needs and health conditions. Staff with responsibility for caring for people with complex needs had not read the care plans and risk assessments on how to meet their needs. Revised guidance and information on people's complex needs was not available for staff to reference. Staff did not receive induction or supervision to ensure they had the right skills and knowledge to support people using the service.

The Deprivation of Liberty Safeguards (DoLS) had not been followed and policies were out of date. The DOLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. The provider had not recognised or considered that people at the home may have been cared for in a way that deprived them of their liberty. For example, by the use of restraint and restrictions. The requirements of the Mental Capacity Act (MCA) had also not been met. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves.

We were not assured people always had a balanced diet as accurate records had not been kept. We also found that people missed health check appointments because the system to manage appointments was not effective. People's health care needs were not always monitored and assessed appropriately.

People were not consistently supported by caring and kind staff who respected them. Some staff had been swearing while working with people. Some people had experienced stressful events and we could not see evidence to demonstrate they had always been emotionally supported afterwards. We were concerned that people felt pressurised by staff and staff did not listen when people made their own choices. We found people's privacy was respected.

Opportunities to learn from complaints were not taken, and the provider had not sought the views of people using the service, families, staff or other professionals about the care being delivered or service provided.

The culture of the home was not open or inclusive. The views of staff had not been acted on when opportunities to improve the service could have been taken. Staff were not supported to question their practice and resources were not used to ensure improvements to staffing levels were effective. The provider did not notify CQC about incidents that it was legally required to do so.

The service did not provide people with care that met their needs and promoted their rights and quality

Summary of findings

assurance systems were inadequate. Records regarding people's care and welfare had either not been retained by the service or comprehensively completed. Systems and processes to record, assess, analyse and mitigate risks and promote people's well-being were not being followed.

Following our inspection, the local authority supported people to move from the home to other accommodation. At present, there are no people living at the home.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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.

The service did not take a robust approach to keeping people safe and procedures for dealing with emergencies were inadequate. There were not enough staff to meet people's needs and staff were employed without employment checks being completed. Processes for the administration and storage of people's medicines were not adequate.

Inadequate

Is the service effective?
The service was not effective.

Arrangements for supervision, appraisal and induction did not develop staffs' skills and knowledge required to meet the complex needs of people. Arrangements in place to manage people's money and restrictions applied to people had not been taken in line with legal requirements, including the Deprivation of Liberty Safeguards. People had missed healthcare appointments and we were not assured people always received a balanced diet.

Inadequate

Is the service caring?
The service was not caring.

Some staff practice had developed that was inappropriate and unprofessional. While some staff worked calmly with people, we observed some practice that was not patient or caring.

Requires improvement

Is the service responsive?
The service was not responsive.

The service did not take opportunities to learn from complaints. It also did not create a transparent process where people using the service, families, staff and other professionals could raise concerns. People did not receive care that met their individual needs.

Inadequate

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

Processes were not followed to ensure effective assessment, monitoring and mitigation of risks to people's health, safety and welfare. Important records had not been properly maintained. The service had not made improvements that had previously been identified and it was not clear on when further improvements identified would be completed. There was no registered manager.

Inadequate

Saint Josephs Specialist Care Home

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 11 May 2015 and was unannounced. The inspection team consisted of two inspectors. We carried out this inspection in response to some information of concern that had been shared with us.

We observed the care provided to four people living at the home and spoke directly with one person. On the day of the inspection we spoke with two visiting social care professionals and one health care professional who were involved in supporting people's care at Saint Josephs Specialist Care Home. We spoke with five members of staff, including the new manager and the provider.

We observed how staff spoke with and supported people living at the service and we reviewed the care records for the five people living there. We reviewed other management records relating to the care people received. This included staff recruitment and supervision records, accident and incident records and medicines administration records.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2015, we asked the provider to take action as people were not safeguarded against the risk of abuse. This was because steps to identify the possibility of abuse and prevent it before it occurred had not been taken and arrangements were not in place to ensure control or restraint was used proportionately. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found adequate improvements had not been made.

During our inspection of May 2015, one person told us a member of staff had been disrespectful, hurtful and had ridiculed them. Despite the provider being aware of this, they did not take further action to satisfy themselves that this member of staff was suitable to continue working with people in the service. We made a safeguarding referral to the local authority who are the lead agency for responding to and investigating safeguarding concerns. We made the referral because the provider had failed to do so. We made a further safeguarding referral for a financial irregularity with one person's money held by the provider. This had not been investigated to establish if theft, misuse or misappropriation of money had occurred. There were no effective safeguards in place to prevent abuse, or respond appropriately when actual or potential abuse had been identified.

In addition, people living at the home were not protected from abuse that could potentially breach their human rights. The provider was not able to demonstrate that staff followed appropriate guidelines when they used physical restraints on people, neither could they demonstrate that the restraints used were a proportionate response to the risk of harm. Some staff used physical restraints on people that were not an approved technique and had not been adequately risk assessed. The provider told us they were unaware of these practices, as well as other restrictions placed on people that impacted on their freedom and autonomy. There were no effective safeguards to ensure the controls and restraints people experienced were lawful and proportionate. This showed that systems and processes had not been established and operated effectively to protect people from the risk of abuse and improper treatment. The provider had failed to ensure that allegations of abuse had been properly responded to. **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At our previous inspection in January 2015 we asked the provider to take action as people were not protected against the risks of receiving care or treatment that was inappropriate or unsafe. In addition procedures were not in place for dealing with emergencies. These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had not been made.

People using the service, could at times, express behaviour that put themselves or others at risk, and had been assessed as requiring physical restraint by staff to keep them safe. New guidance for the use of physical restraint, based on best practice, had not been made available to staff to use, nor included within people's care plans. In addition, risk assessments and care plans did not provide sufficient detail on people's health conditions to enable staff to provide safe care by mitigating known risks.

People were also not protected from the risk of foreseen emergencies as emergency procedures at the home were not well managed. People using the service had behaviour and anxieties that could put them at risk should they need to evacuate the premises due to an emergency, such as a fire. New personal emergency evacuation plans, (PEEPS), had not been made available to the staff team and staff were not aware of what procedures they should follow in an emergency situation. In addition, a fire exit door would not open and alterations had been made to the fire alarm panel which prevented the location of a fire being identified quickly. Staff were therefore unable to take all necessary action to respond to a fire in a way that protected people living at the home from unnecessary risks. **These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At our previous inspection in January 2015 we asked the provider to take action as they had not ensured that before staff started work they were suitable to work with people who lived at the service. These were breaches of Regulation 21 of the Health and Social Care Act 2008 (Regulated

Inadequate

Is the service safe?

activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found adequate improvements had not been made.

During our inspection of May 2015, we found the provider was still not operating safe recruitment practices. We found members of staff had been employed without the provider completing checks designed to confirm they were of good character and suitable to work in positions of trust with people living at the home. In addition, when one recruitment check identified a significant issue of concern, the provider failed to consider whether this staff member should be employed. The provider had failed to ensure people employed were suitable to support people living at the home. **This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At our previous inspection in January 2015 we asked the provider to take action as people's health, safety and welfare was not safeguarded as there were not sufficient numbers of staff for carrying on the regulated activity. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had not been made.

During our inspection in May 2015, there were not sufficient numbers of staff available to meet people's needs and keep them safe. People using the service required high levels of support from staff to ensure they were not at risk. We observed people showing signs of anxiety because at times there were not enough members of staff available to meet people's needs. We spoke with the new manager who told us there was not enough staff working at the home. They had been unable to fulfil their managerial role because of low staffing levels and had been working to provide care and support directly to people. This meant that the provider had not ensured sufficient staffing levels to ensure people's needs were appropriately met and to ensure their safety. **This was a breach of Regulation 18 of the Health and Social Care Regulations 2008 (Regulated Activities Regulations) 2014.**

At our previous inspection in January 2015 we asked the provider to take action as medicines were not always stored securely, errors were made in medicines administration and no guidelines were in place for when some types of medicine should be administered. Medicines had also been overstocked and not disposed of appropriately. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had not been made.

During our inspection in May 2015, we found systems in place to manage medicines did not ensure people's safety. There was limited evidence that people had received their medicines when they required them. People using the service had complex needs and used medicines to help them manage their health conditions and behaviours, which could sometimes present risks to themselves or others. No guidelines were in place for people who were prescribed medicines to take 'as and when required' to help them manage their behaviour. Without these guidelines we cannot be assured people received the maximum benefit from their medicines and were helped to manage their behaviour in a least restrictive way. In addition, we also found occasions where records showed people had not been given prescribed medicines to help them manage their behaviours. Staff were unable to confirm whether people had received their required medicines due to poor monitoring and poor recording practices.

Suitable arrangements were not in place for ordering and disposal of medicines which meant the provider had more stock than was required. They had also not disposed of medicines appropriately. These issues were identified at our previous inspection and had not been rectified.

The medicines cupboard door had a large hole in it as a result of an incident of criminal damage. This compromised the security of medicines being stored in the cupboard and posed a risk to people living at the home from the potential to access unsecured medicines. The provider had failed to recognise that medicines were not being stored appropriately. As proper and safe arrangements were not being followed for the storage and recording of medicines people were not fully protected from the risks associated with medicines. **This was a breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.**

Inadequate

Is the service safe?

We found that the premises and equipment used by the provider had not been properly maintained. People using the service were directly affected by the improvements required to their living environment. For example, one person enjoyed watching television in the lounge and they were not able to so because the broken television had not been replaced. There were no toilet seats and no hand soap dispensers for all the downstairs toilets. A fire exit door would not open and the damaged medication cupboard doors had not been replaced. There were numerous holes in walls and broken window blinds, curtains and a bathroom tap. The provider was not aware of any timescales for when the issues we identified would be completed. The provider did not have an effective system for ensuring the property was maintained and in an acceptable state or repair. **This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Inadequate

Is the service effective?

Our findings

At our previous inspection in January 2015 we asked the provider to take action as staff were not supported in their responsibilities to deliver safe care and treatment to people using services. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that adequate improvements had not been made.

During our inspection of May 2015, we found staff had not been supported to acquire the knowledge and skills needed to support people living at the home effectively. People who used the service required staff to have an in depth understanding of their complex needs, and their behaviour management strategies, that if not correctly followed, could result in the person putting themselves or others at risk. Since our last inspection, staff we spoke with had not received any supervision or an appraisal of their performance from a manager. Plans to support staff through continual professional development had also not been introduced. One member of staff told us they had started work at the service with no induction nor any time spent shadowing more experienced members of staff in order to learn and understand the needs and behaviours of the people who used the service. We were concerned that staff were supporting people with complex needs without any supervision of their practice or appraisal of their performance. Staff had not received appropriate induction, support and supervision from the provider to enable them to care for people with complex needs and associated behaviours such as those living at the service to the required standard. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At our previous inspection in January 2015 we had asked the provider to take action to ensure suitable arrangements were in place to act in accordance with people's consent, and meet with the full requirements of the Mental Capacity Act (2005) where people lacked capacity to consent. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that adequate improvements had not been made.

During our inspection of May 2015 we found the principles of the Mental Capacity Act (MCA) 2005 were still not being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Assessments of people's capacity for decision making over a variety of issues were not fully completed and we saw restrictions introduced to people's care without any regard to the MCA. What was in people's best interests had not been considered and there was a lack of involvement and engagement with people and their representatives about such changes. **This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

In addition, at our previous inspection in January 2015 we asked the provider to take action to ensure people were safeguarded against the risk of abuse by having arrangements in place to ensure such control was otherwise not excessive. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that adequate improvements had not been made.

During our inspection in May 2015, we found that arrangements were still not in place to ensure the restraint of people who lacked mental capacity was taken in line with Deprivation of Liberty Safeguards (DoLS). DoLS is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. No application for a DoLS had been made for the person we identified as having their freedom restricted at our inspection in January 2015 and the DoLS policy had still not been updated. These meant restrictions may have been placed on this person unlawfully. **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

One health professional we spoke with during our inspection in January 2015, expressed some concern that a

person had missed a health check appointment. People using the service required care and treatment from other external professionals including GP's, dentists and other specialist therapists. During our inspection in May 2015, we found that people were not always supported to access healthcare services to maintain their health. Staff told us one person had missed a recent health check as staff were unaware of the appointment. We also found a letter confirming another health check had not been recorded in the appointments diary and so staff responsible for the care and support of this person would not know about the appointment. Records also showed that one person had injured themselves and although they were taken to the accident and emergency department, it was reported that staff did not stay long enough with them to receive treatment. Records showed they did not receive any treatment. **This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Arrangements to support people to maintain a balanced diet and have sufficient food and drink were not effective. People using the service had access to the kitchen area for snacks and drinks throughout the day. However, no menu plans were in place for main meals and staff were not able to tell us what was planned for dinner. Staff told us people had not recently been asked what food they would like to eat and until recently there had been an absence of fresh foods. We found fresh food during our inspection and although staff did not know what was going to be for dinner earlier in the day, staff had prepared an evening meal. However, when we looked at records of people's food intake we found these had not been routinely kept and we could not be assured that people were being supported to maintain a balanced diet.

Requires improvement

Is the service caring?

Our findings

During our inspection in May 2015, we were concerned that some staff had not developed positive caring relationships with people using the service and those staff were not talking to people appropriately. We were not able to gain people's views directly on what they thought about the staff team because some people did not want to talk with us, people had complex needs that affected this topic of conversation and other people were not available at the time of our inspection. Prior to our inspection we received some information of concern regarding staff swearing when talking with people using the service. We spoke with the manager about this who confirmed it had happened and told us they had recently told staff this was unacceptable. We were concerned that some staff were talking with people inappropriately and had not, until recently, been challenged by management.

We were not assured that staff treated people with dignity and respect. During our inspection one person disclosed to inspectors and the provider that a member of staff had ridiculed them. The person was upset about this and told us they felt the member of staff had not treated them with respect. We were concerned that the provider's response did not demonstrate sufficient regard to the person's experience. For example, the provider changed the topic of conversation away from what the person was talking about and did not ask them whether they needed any further support or whether the actions proposed by the provider reassured the person.

In addition, we were concerned people had not received caring support after experiencing stressful events. We were aware of some further incidents where property had been damaged and where some people in the service had been assaulted. Comprehensive records were not available on the day of our inspection to demonstrate that people involved in these incidents had been asked how they felt and given the opportunity to receive emotional care and support from staff.

People were not being supported to express their views and make choices about how their care and support was provided. There was limited evidence that people's decisions about their care had been respected by staff. We observed some members of staff working calmly with people to support the choices they made, for example, to go out on a walk. However, we also observed one member of staff showing signs of impatience and exasperation when one person expressed reluctance to go on an activity. This provoked anxiety in the person who then quickly agreed to the activity. We were concerned that the person was coerced into attending an activity they did not want to do. We were concerned that the staff member had not supported this person in a caring or compassionate way. For example, they did not offer reassurance to the person that it was acceptable for them to change their mind and to support their sense of independence.

We saw that staff respected people's privacy. During our inspection we observed one person chose to spend time alone in their room and this was respected by staff. We saw each person had their own bedroom with en-suite facilities. Staff told us that people would spend time in their rooms when they wanted to.

Inadequate

Is the service responsive?

Our findings

Staff were not aware of people's individual needs and told us conflicting information about what people's needs were. Staff had not read people's care plans to understand what care and support people required. People using the service had complex needs and could express behaviour that placed themselves or others at risk. The care plans we looked at contained important details of people's preferences as well as what could trigger people to act in ways that could cause risk to themselves or others and what strategies staff should follow to de-escalate behaviours or anxiety. Staff were unable to tell us this information in a consistent manner.

Some staff we spoke with were unable to identify what health conditions people who used the service had, in addition some staff had started work directly with people without any knowledge of their needs or preferences. As staff were not aware of people's individual needs and requirements, they were unable to meet their needs. This evidence demonstrates that the provider failed to ensure that people received care and treatment that was appropriate, meets their needs and reflects their preferences.

People's care needs were not properly assessed, reviewed and recorded. People using the service had complex needs and required their care to be reviewed from other visiting health professionals. We found one health care professional had requested that staff monitor and record certain features of a person's health care condition. This was so that the person's health care condition could be properly assessed and reviewed for any changes that would require an alteration to their care and treatment. However, we found that staff had not completed any of the requested monitoring forms to report on this person's health condition and therefore, no meaningful review and assessment of their condition could take place. **This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We expressed concern during our inspection in January 2015 and again, during a further meeting with the registered manager in March 2015, that there was not a process in place for the service to be developed with people using the service, staff, families and other professionals. No action had been taken to improve this.

During our inspection in May 2015, we found the provider did not routinely listen and learn from people's experiences, concerns and complaints to improve the quality of care. When a person using the service raised a concern with the provider about a member of staff they were not asked whether they wanted to, or provided with any information to help them understand how to, make a complaint. The provider told us they were aware of another complaint made against the service. However, they later told us, "It wasn't really a complaint," and they had not recorded the complaint or their response to it anywhere. The provider described the complaint and it was clear there were opportunities to learn from the situation and these had not been taken. There was no effective system in place for people to share their concerns and have these contribute to improvements in the service.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in January 2015 we asked the provider to take action as systems were not effective in assessing and monitoring the quality of the service and identifying, assessing and managing risks to the health, welfare and safety of people using the service and others. In addition, records had not been appropriately maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that adequate improvements had not been made.

During our inspection we identified significant shortfalls in all aspects of the running of the home. This included failures in safeguarding practices, support and recruitment of staff, medicines management, planning and delivery of people's care and following relevant legislation such as the Mental Capacity Act. As a result, the service was not delivering care to people that reflected their changing needs and kept them safe.

Records for some significant incidents involving people using the service were either missing or not completed. There were no systems in place to learn from such incidents and mitigate risks to people in the future. Records that were available for other incidents did not sufficiently identify and mitigate risk as care plans and risk assessments had not been updated to reflect any learning. This was important given the nature of these incidents and the complex needs of people using the service.

We also found that quality assurance systems were not being completed. The system to check the stock and re-order supplies for the first aid box had not been followed because the member of staff responsible had not been at work and no other member of staff had completed the task in their absence. There was therefore a risk that people using the service and staff who sustained injuries and required supplies from the first aid box would not have access to this treatment. We also found out of date food in a refrigerator that had not been removed because staff had not completed the quality assurance process to identify and remove food that was out of date. This meant there was a risk to people using the service of consuming food that was out of date.

Other systems and processes designed to check the quality and safety of people's care did not fully protect people from the risks of receiving unsafe or ineffective care and treatment. We found there was no evidence to show MAR charts had been audited to identify and investigate when staff had not signed to say a person had received their medication as prescribed. There were also no records made of further investigation and audit when records showed a financial irregularity with a person's money.

During our inspection in May 2015, a number of records were unavailable for us to review and the provider told us they had given these records to other health and social care professionals. We found other records had not been properly maintained, nor appropriately audited and analysed. This included incomplete records such as daily records of people's well-being, food intake and weight monitoring. There were no health monitoring forms completed as requested by a healthcare professional for a person. The service had therefore failed to keep accurate, complete and contemporaneous records in respect of each person's care and treatment and decisions taken in respect of that care and treatment. **These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The provider did not fulfil its responsibilities to send statutory notifications to the Commission. Notifications are changes, events or incidents that providers must tell us about. Since our inspection in January 2015, the provider had sent through statutory notifications to advise us of incidents involving the police. However, we were aware of other incidents that would require a statutory notification to be submitted, for which none were received. These included notifying us about the absence of a registered manager, injuries to people using the service and allegations of abuse. **These were breaches of Regulations 14 and 18 of the Care Quality Commission (Registration) Regulations 2009.**

We found there was no system for people using the service or their families to contribute their opinions on how the service could improve and develop. We also found staff views and opinions on how the service could improve were not acknowledged and considered. Some staff also told us they felt it was difficult to raise their concerns and made suggestions directly to the provider. Another member of staff told us they could talk to their manager if they had a concern, but that they were, "Not sure they will do

Inadequate

Is the service well-led?

anything." In addition, we found staff had not been supported to question their practice and this had led some staff to develop inappropriate ways of working with people. One member of staff told us they had recently challenged the poor practice they had observed and told us there were, "No professional boundaries here." They also told us there was, "No structure," and they found working at the service, "Quite stressful." The service did not promote a positive culture that was person-centred, open, inclusive and empowering.

Saint Josephs Specialist Care Home is required to have a registered manager. The previous registered manager had stopped working at the service from on 22 March 2015 and had submitted an application to be removed from our register. At the time of our inspection, the new manager had worked at the service for four weeks and had not applied to register with the Care Quality Commission. The manager had not been given time to fulfil their management role because the service had been short of staff and they had been working providing direct care to people using the service. On the day of our inspection we observed the manager working all day directly with people using the service and taking a person out on an activity. Resources had not secured enough staff to allow the manager to fulfil their role. The service did not demonstrate good management and leadership.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate induction, support and supervision from the provider to enable them to care for people with complex needs and associated behaviours such as those living at the service to the required standard. They had also failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs. These are breaches of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments did not fully consider people's health condition in relation to their care and treatment. Proper and safe arrangements were not being followed for the storage and recording of medicines. The registered person failed to ensure the premises were safe and being used in a safe way. These are breaches of Regulation 12(1) and (2)(a)(b)(d) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

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

Enforcement actions

The registered person has failed to ensure care and treatment provided to people was appropriate, met their needs and reflected their preferences.

This is an on-going breach of Regulation 9(1)(a)(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

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

The registered person failed to maintain securely, and accurate, complete and contemporaneous record of people's care including their care and treatment and decisions taken in relation to that care and treatment. Processes and systems to design to check the quality of services and mitigate risk to people using the service were not effective. Records necessary for the management of the regulated activity were also not maintained securely.

This is an on-going breach of Regulation 17(1)(2)(b)(c)(d)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence

The provider did not fulfil its responsibilities to send statutory notifications to the Commission.

These were breaches of Regulations 14(1)(b) and (2)(a)(b)(c)(d) and (e) of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not fulfil its responsibilities to send statutory notifications to the Commission. These were breaches of Regulation 18(1)(2)(a)(iii)(b)(ii)(e) and (5)(b)(ii) of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person has failed to protect people using the service from restraints, restrictions and controls that are unlawful or excessive. This is an on-going breach of regulation 13(1)(3)(4)(b)(5)of the Regulated Activities Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The Registered person had failed to ensure the requirements of the MCA were met where people did not have capacity to consent to decisions. This was an on-going breach of Regulation 11 (1)(2)(3)(4)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person has failed to ensure fit and proper persons are employed to work with people using the service. This is an on-going breach of Regulation 19(1)(a)(b)(c)(2)(a)(b)(3)(a)(b) of the Health and Social Care Cat 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered provider failed to maintain premises to an acceptable state of repair. This is a breach of Regulation 15 (1)(e) of the Regulated Activities Regulations 2014.

The enforcement action we took:
We took action to cancel the provider's registration of the above regulated activity at this location.