Autism Care Wiltshire Limited

Ciderstone House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ciderstone House is a residential care home providing personal care and support for up to six adults with learning disabilities and autism. At the time of the inspection, six people were being supported.

Ciderstone House accommodates four people in one building and two people in self-contained annexes attached to the building.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
The registered manager and provider were not providing consistent leadership and support at Ciderstone House. Staff felt unsupported and felt their views were not respected or valued. Management had not demonstrated the principles of good quality assurance and therefore systems and processes to provide an overview of the service were unclear and confusing leading to risk.

People's safety was not always optimised. Relatives did not feel fully confident that family members supported at the service were always safe. Staff did not always have the level of experience necessary to work with people with complex needs. We found improvements needed in respect of staff training in safeguarding and other aspects of safety such as infection control and food safety. This training had not been completed as per the provider's policy. Therefore, staff did not have the relevant learning to support people effectively and safely. Not all staff we heard from were confident about raising concerns internally with the provider. Information about risks associated with people's needs were not clear and readily accessible. The management of medicines needed improvement. The provider acknowledged that lessons had been learnt in the acquisition of the service and provided assurance that areas of improvement were being worked upon.

People's needs had not been reviewed to ensure best practice guidance was used to achieve effective outcomes. Staff did not have the support in place to ensure they felt confident to deliver care to people with complex needs. People's health need requirements, such as specialist health appointments, were not always known about so that the provider and registered manager had a good overview to manage people's health conditions. People's nutritional needs were not always being met to ensure their diet was healthy and adequate to maintain good health.

People were not always supported to have maximum choice and control of their lives and supported in the

least restrictive way possible. We have made a recommendation about ensuring the principles of the Mental Capacity Act 2005 are consulted.

People were supported by staff that cared for them. However, the provider had not ensured that people were supported with consistent staffing in relation to their autism. This meant that people were not always supported by staff that had the time to get to know them well and understand their care and support needs, wishes, choices and any associated risks.

People's care needs were not regularly reviewed. Care plans were muddled and incomplete which meant staff could not always access all information about people. People did not always have opportunities to pursue their interests and hobbies.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. People using the service did not receive consistent, planned and co-ordinated person-centred support that was appropriate and inclusive for them.

The provider was actively addressing the issues that had been raised during the inspection and demonstrated a willingness to work transparently and openly with all relevant external stakeholders and agencies.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was Outstanding (published 27 May 2017). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
This was a planned inspection based on the previous rating. However, just prior to the inspection we received information of concern from anonymous sources. These included, people not being supported by sufficiently experienced staff as training had not taken place. There was also concerns expressed about unsafe medicines management

We have identified four breaches in relation to person centred care, safe care and treatment, staffing and good governance at this inspection. We have made one recommendation in relation to the Mental Capacity Act 2005.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ciderstone House on our website at www.cqc.org.uk.

Follow up:
Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Ciderstone House

Detailed findings

Background to this inspection

The 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
The inspection was undertaken by one inspector.

Service and service type:
Ciderstone House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 comprehensive inspection was unannounced.

What we did:
Before our inspection
We reviewed information we held about the service. This included the last inspection report, information received from local health and social care organisations, and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection
We spoke with the assistant regional director, the registered manager, deputy, and a manager who had just started working in the service. We spoke with three members of staff who work at Ciderstone on the day of the inspection. We also spoke with the Positive Behaviour Support Specialist. To help us assess how people's care needs were being met we reviewed two people's complete records and referred to the other people's records for information about risks. We also looked at the medicines records for all people, and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

After our inspection
We continued to seek clarification from the provider to validate evidence found. We emailed and heard back from a number of staff who work at the service. We also spoke with three relatives for their feedback about the service. After the inspection, we also spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People living at Ciderstone House were not able to verbally share their experiences of living at the home. Therefore, we spent time observing staff with people and sought the views of people who knew them well.
- Not all staff had received safeguarding adults training. We saw that only 22 out of 44 staff had received this training which the provider had stated was mandatory. Safeguarding training provides staff with the skills to help identify who may be at an increased risk of mental or physical abuse or neglect.
- Staff were aware of whistleblowing policies and procedures but not all were confident in following them. Staff comments included, "Whistleblowing is the term used when a worker passes on information concerning wrongdoing. I unfortunately don't feel confident. I have raised concerns and don't feel like these things are being actioned in the timely manner they should be." Another member of staff said, "I would feel partly confident, but some issues I've had are to do with the amount of staffing but am getting told it depends on funding."
- Relatives did not feel completely confident about their family member's safety. Comments included, "I didn't use to worry but I do now. Just unsure of what's going on." They went on to say, "There was a safeguarding incident that I wasn't told of. This is being investigated now but I haven't heard back as promised."

We found no evidence that people had been harmed. However, people were not protected by effective systems and processes to keep them free from the risk of abuse. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- The provider had acquired the service in May 2019. The service was not audited effectively until October 2019. Audits would have assured the provider that people's risks were known about and accurately recorded to inform staff. The provider had not ensured that staff training was up to date and appropriate to support people's identified needs. This meant the assessment, monitoring and management of risks was not in place.
- Information about risks to individuals were not easily or clearly accessible. For example, we were initially given incomplete records to review and then informed that the staff were not using these incomplete records. We were then given current records in use but found these did not contain all essential information about risks. The records were incomplete and held in different places. We asked what information was used for staff who were not familiar with people, We were told that a pre-shift summary was used. On examining these, we found that essential information was not on these summaries. For example, stating a person had epilepsy. Three people did not have any pre-shift summary on their records. This meant information about

risks was not easy to access to ensure staff could keep people safe.
● Agency staff were being used in the service who did not know people well. This meant it was essential that up to date and accurate information was available about people's risks.
● People were at risk of harm because the environment was not always kept safe. On walking around the premises, we found the laundry door unlocked and within that the cupboard containing cleaning liquids was also unlocked. This could propose a risk if a person got into the room undetected.

We found no evidence that people had been harmed. However, people's care and support was not provided in a safe way as not everything was being done to reduce identified risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● There were not always enough staff with the right mix of skills, competence and experience to support people to stay safe. A number of existing staff who had worked with the previous provider had left. Therefore, there were new staff in post and the provider was also using agency staff whilst they recruited. We looked at the agency profiles of staff and saw that none of them had epilepsy training. We raised this with the registered manager who said that agency staff did not work alone with people. However, we saw on two days of the inspection a person with epilepsy supported alone by an agency member of staff.
● We had comments from staff who felt staff with the appropriate skills and experience were not always being recruited to work in the service. Comments included, "Staffing is the same level but their knowledge is not and this is worrying. Staff need time to get to know people. We need the right staff with the right experience" and "We could do with more support. We have a lot of agency currently and it is hard work to support them as well as people. A lot of staff have left and sickness levels are high."

We found no evidence that people had been harmed. However, people were not being cared for by staff that had the competence, skills and experience to support them safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Recruitment systems were in place and appropriate recruitment checks were carried out.

Using medicines safely
● The service had not carried out any audits on medicines until very recently since acquiring the home in May 2019.
● Before the inspection, concerns had been raised that epilepsy medicines were not always been given as prescribed. These medicines are time specific and this is essential to ensure symptoms are managed. We saw notes at a meeting on 21/11/19 that stressed how important it was for people with epilepsy to have their medication at regular times. A plan had been put in place to ensure this happened.
● On the first day of the inspection, there was some discrepancy about the balance of one 'as needed' medicine. We discussed this with the registered manager but they were unable to find out where this medicine was.

We found no evidence that people had been harmed. However, people were not always protected by the safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● A recent check had been done and stock and ordering of medicines were being rectified.

● At the time of the inspection, the service was changing the way it managed medicines. A new system of pre-packaged medicines was being put in place.
● We checked the medicines protocols and MAR sheets which were completed as per policy.

Preventing and controlling infection
● Not all staff had received infection control training or food hygiene. Only 10 out of 44 staff had undergone this training. Prevention of infections is the responsibility of all care staff to assess risks, prevent, detect and control the spread of any infections.
● Only 13 out of 44 staff had completed food safety training. The cook did not have food safety training. This training ensures staff have the appropriate training when handling or preparing food to avoid potential risks such as food poisoning. Both of these training requirements were stated as mandatory on the provider's policy on staff training. Staff not receiving training in this area meant people were not always kept safe from these risks.

We found no evidence that people had been harmed. However, the provider was not ensuring that infection control systems and process were being followed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The premises were clean and free from odours.

Learning lessons when things go wrong
● The provider acquired the home in May 2019. The nominated individual, registered manager and area regional manager stated lessons had been learnt. This included ensuring any newly acquired services were fully audited upon acquisition.
● In light of the concerns raised and investigations, the service was working in collaboration with the local authority and other professionals to ensure the issues that had emerged were being rectified in a short timescale. This helped to reduce the risks identified.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The delivery of care and support was not consistently in line with best practice guidance. For example, the provider was not following best practice guidelines in line with Registering the Right Support (RRS) and National Institute of Clinical Evidence (NICE) to achieve effective outcomes.
- Prior to people moving to Ciderstone House, the previous provider's had undertaken a full assessment of people's needs to ensure these could be met. However, these assessments had not been reviewed when the service was acquired by the new provider. Therefore, the provider was not assured that they were continuing to meet people's current needs.

We found no evidence that people had been harmed. However, people's needs had not been fully assessed to ensure their care and support was designed and delivered to meet their needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

- Staff were not fully supported when they started working in the service. The provider's training and development policy outlined induction requirements including training. Not all staff felt they had an adequate induction in respect of working with people with complex needs. A member of staff commented, "The support given to me was to shadow a senior for a couple weeks (even though it was only a few days) and read the service users care plan and risk assessment. I don't feel like I have the full experience to look after them, there's still things I don't know but we can ask our seniors for help." Another member of staff said, "I wasn't given any support to care for any of the service users. I shadowed a couple of times and was then just thrown in the deep end to do it all myself and figure it all out myself." We saw a comment on an internal compliance audit in October which stated, 'Three new staff started on Monday; two had left by Thursday and one was left to support a person on her own."
- Training was not in place for all staff to ensure people's care and support needs were safely and effectively met. The training policy said that mandatory training including first aid, health and safety, food safety, infection control, managing violence and aggression would be completed within 10 weeks of staff starting work. We reviewed the training matrix and found many gaps where this mandatory training had not taken place. We had feedback from some staff that they did not feel they had the level of training they needed. Comments included, "Sometimes I don't feel like I can care for people safely as I have had no training on anything such as epilepsy and most of our service users have epilepsy. I don't feel confident enough to work with these service users alone especially out in the community but feel like I won't be listened to if I spoke up

about this due to not being allowed to refuse to do anything or I could potentially face going down the disciplinary route."
● Staff did not have any supervision meetings until the end of October 2019. Staff told us they did not always feel supported. A member of staff told us, "I have had a supervision but I don't feel confident to raise any concerns I have as I feel like all the seniors and management talk and are friends they are not going to do anything or won't solve the problems I have or they will talk about it and not help." There had been no staff appraisals since the current provider had acquired Autism Care Wiltshire (ACW) in May 2019.
● We asked the registered manager why supervisions had not taken place. They advised that not having a home manager in post had impacted upon this. They had put plans in place to ensure these took place on an ongoing basis and we were assured that staff had been met with on a one to one basis to discuss changes being made following Choice Care Group's purchase of ACW.

We found no evidence that people had been harmed however, staff induction, training and support was not adequate to enable staff to carry out their duties they are employed to perform. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider responded immediately during and after the inspection. We asked the registered manager and area regional director about this and they said that trying to balance covering shifts and releasing staff for training was a challenge and there was an action plan in place to ensure this was completed as soon as possible. A plan to ensure regular supervision meetings were held with each member of staff was also in place.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's health needs were not consistently acted upon. We asked for information about health appointments. This included people's annual health checks with a GP. The management were unable to find out if, or when, these had been completed. They said the information was in a locked cabinet which they could not access. Later in the day, the manager called the GP surgery and was updated by them about whether the checks had taken place or not.
● Following a local authority monitoring check in October, the service had referred people to have epilepsy reviews. However, this had not been proactively carried out and was in response to the local authority findings. We found these epilepsy reviews were outstanding but the manager was asking for these to be prioritised.

We found no evidence that people had been harmed. However, the provider was not ensuring that care and treatment needs were shared with appropriate persons to ensure timely care planning to ensure health and safety of people. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
● People were encouraged to make healthy food choices. However, one relative had concerns about their family member who had put on weight and their concern about this. We heard from the registered manager that the cook was working with this relative to ensure menus were appropriate alongside providing choice.
● The main meal was prepared in the adjoining service and brought down to the house. People could then be involved with helping prepare breakfast and lighter snacks later in the day. We heard that people helped with cooking when possible.

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service had not ensured that all people had consented to care and treatment, in line with guidance in the MCA. Consent had not been checked or audited in areas including the use of monitors in epilepsy. This meant that consent to care and treatment and best interests' decisions had not been obtained in line with legislation and guidance, including the MCA 2005 or Deprivation of Liberty safeguards. The management were in the process of updating all the required documentation in line with their action plan.
● All people had a DoLS authorisation. However, these had expired and had been re-applied for by the previous owners and were awaiting assessment and further authorisation. The service's action plan stated that any restrictions on the DoLs were adhered to until the new authorisation was received .

We recommend the provider consider current guidance on the Mental Capacity Act 2005 and take action to update their practice accordingly.

● Not all staff had received MCA/DoLS training but indicated their understanding. Comments included, "If I am working with a service user I will let them choose what they wear. I'll just make sure it's sensible for the weather, if they want a snack I'll let them pick but make sure they are allowed it" and "We always assume the client has capacity and can make their own choices, we have a client where we have had to get DOLS in place for his own safety for a sleep pod in his room."

Adapting service, design, decoration to meet people's needs
● People's environment continued to be personalised to reflect their preferences. The house had a sensory room which could be used as a quiet place. People had access to outside space.

Requires Improvement

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.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were unable to provide verbal views about the caring attitude of the staff. We therefore observed people during the inspection and spoke with relatives who knew individuals well.
- At times, there was little meaningful interaction between people and staff. On the first day of the inspection, a person was approaching members of staff but did not receive a response so they repeatedly came to the inspector for interaction.
- Relatives said they recognised that staff were doing their best. However, they felt the number of unfamiliar staff caused anxiety to their relatives. Inconsistent staffing did not always ensure that people had staff supporting them that had the time to get to know them well and understand their care and support needs, wishes, choices and any associated risks. This is important with autism as consistency and routine are essential.
- Relatives did not always feel welcome when visiting Ciderstone. They felt the atmosphere was tense and also, they felt uneasy about seeing staff they did not know supporting their relatives. One relative said they would appreciate having updates about who the staff were and have photographs, names and roles so they could relate to them when they visited.

- The provider had not done everything they could to facilitate a caring and compassionate service. For example, they had not ensured that staff had the knowledge and skills they needed to support people. Only seven out of 44 staff had completed person centred care and equality and diversity training. This training provides information and understanding to staff about person-centred approaches and care and how to reflect on their own practice and its impact on the people they support. Staff have a key role in improving quality of care by understanding equality and human rights for people using services.
- We did observe other staff supporting people in a warm and friendly way. Staff we spoke to told us how much they cared about the people they supported.
- There was evidence that people's relatives were being updated regularly about their loved ones to provide reassurance.

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

- People were not able to verbalise their experiences of the service. Reviews of people's care in conjunction with their family members, had taken place for three people from September onwards and a further three were planned.
- Some people's views had been incorporated into the existing care plans, and we could see relatives were involved in their care planning. Draft care plans had been sent out to families for comments and input.

Respecting and promoting people's privacy, dignity and independence

● There were arrangements in place to provide people with privacy. Our observation showed staff maintained people's privacy during the day with personal hygiene being attended to in private.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care needs were not regularly reviewed. The care plans were muddled and incomplete which meant staff could not always access all information about people.
- People were dependent upon staff supporting them to follow and take part in their interests or hobbies and maintain contact with the community and its resources. Most people needed one to one support or sometimes two staff for one person when outside the service. At the time of the inspection there was limited information about what people were doing.
- People's daily records to show daily activity were not always complete or informative to give a clear picture of the person's day. Minimal activities were being recorded and were not always consistent with what support plans identified people enjoy doing for activities. On the first day of the inspection, there were limited activities or outings taking place. We saw a discussion had taken place at a team meeting and recorded, 'If there isn't any strong staff in the house it is easier to take them out for drives. It is okay for service users to go for drives but not for 4 or 5 hours.'
- Staff commented about the lack of activities. Comments included, "Activities are planned but it's achieving it as we have limited drivers" and "There's not really much for the service users to do within the house. They can watch movies, telly, play games, some of the service users get to go out with a worker. I think there could be more within the homes for the service users to do because at the moment they just are just sitting there for most the day doing nothing and then they start using challenging behaviour because they are bored."

We found no evidence that people had been harmed. However, people's needs had not been fully assessed to ensure their care and support was designed and delivered to meet their needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Management was using information from current support plans to incorporate into the provider's care plan format. The plan was to gain information from all that knew the person well. For example, families and professionals.
- We spoke with the management team who acknowledged that more activities were required and there were plans to improve these.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People had communication care plans from the previous provider which had identified and recorded people's communication needs. These included the use of Picture Exchange Cards (PECS), use of Makaton (a form of language that people use to communicate) and items or photographs. However, we did not see these being used during the day.

Improving care quality in response to complaints or concerns

● People in the service were not able to verbally complain or raise concerns. We asked families how complaints and concerns were responded to. A number of relatives had raised concerns about their relative's care with the provider. We saw that complaints had been dealt with in line with the providers policy and procedures and all had been responded to in writing.

End of life care and support

● The registered manager told us nobody using the service was receiving end of their life care. People were relatively young and had families in constant contact with them. Therefore, the service would contact the families, as they would in any emergency, in the case of a sudden death.

Requires Improvement

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

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager and manager did not have a clear overview of what was happening in the service. On both days of the inspection it was difficult to locate information and have answers to questions about people and the governance of the service.
- Leadership of Ciderstone House was inconsistent. The registered manager was not always aware of information and deferred to other members of staff to answer questions. Information was held in different locations and was not easily accessible throughout the inspection. There was no clear overview of different roles, responsibilities and accountability arrangements were not clear.
- Only one staff meeting had taken place since the provider took over the service. This was held in October and not all staff felt their experience and views were used to improve the service. A member of staff said, "Team meetings are not very regular so I don't feel that we will be listened to and have our views taken into account. Since I have been employed, we have only had one team meeting. I feel we need to have these more regularly so that issues can be addressed and more than one person may have the same issue so it gives us the chance to sort these out."

We found no evidence that people had been harmed however, the quality and safety of the service had not been assessed, monitored or improved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Management had not demonstrated the principles of good quality assurance and therefore systems and processes to provide an overview of the service were unclear and confusing leading to risk.
- Existing systems and processes had not been reviewed upon acquiring the service in May 2019. This meant risks had not been identified or managed and quality assurance arrangements had not taken place until sometime after the provider was in place. This meant that actions and necessary improvements had been delayed which placed people at risk.
- Staff had not been adequately supervised and there was little evidence of ensuring staff were competent to safely and effectively meet people's needs.

We found no evidence that people had been harmed however, the risks had not been assessed, monitored

or mitigated to protect people and staff in the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● Staff did not have the support and resources, such as consistent management, supervision and team meetings to enable the staff team to develop and be heard. A couple of senior meetings had taken place. A member of staff commented, "No, we don't have team meetings there are only management meetings and seniors' meetings. Doesn't feel like we are a team."

● Meetings had been arranged with families and staff on the commencement of the provider taking over the service. Surveys had been sent out to relatives and staff. However, only one relative had responded.

● As staff meetings had not been initially held, the provider had not taken on staff's views and concerns, to act on to shape the service and culture and improve care.

● The findings of this inspection evidence that the service had not ensured learning and improvement had continued.

We found no evidence that people had been harmed however, the provider had not sought and acted upon feedback from all necessary to inform evaluating and improving the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider was aware of the requirements around notifying CQC of certain events, such as Incidents. Required notifications had been submitted as required.

Working in partnership with others

● In addressing the issues that had been raised during this inspection, the service had demonstrated a willingness to work transparently and openly with all relevant external stakeholders and agencies.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs had not been fully assessed to ensure their care and support was designed and delivered to meet their needs and preferences.