HF Trust Limited

Rowde

Inspection report

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

Rowde is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 is registered to provide personal care and accommodation for up to 37 people with learning disabilities and associated health needs. At this inspection 35 people were being supported by this service.

People who use the service live in five bungalows and attached self-contained flats on a central site. The service is run by HF Trust Limited, a national charity providing services for people with learning disabilities. At the last comprehensive inspection in February 2018, the service was rated Requires Improvement overall and in each domain apart from caring, which was rated as Good. A breach of Regulation 11 Consent and a breach of Regulation 12 Safe care and treatment were identified. The provider submitted an action plan to us on how they were going to address these concerns.

The inspection was prompted in part by notification of an incident following which alleged sexual abuse claims have been made concerning people who use the service. Some of these incidents are historical and occurred prior to HF Trust Limited taking over and others have continued during this providers governance. The notification was reported by the service to The Care Quality Commission and the Adults safeguarding team. This incident is currently being investigated by the Adults safeguarding team. The Care Quality Commission are reviewing the information and considering what regulatory action to take.

At this inspection we found the service remained Requires Improvement in the effective domain but was now rated as Inadequate in safe and well-led. We did not inspect caring or responsive at this time. We identified three new breaches of the Regulations, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 17 Good governance and Registration Regulation 18 Notification of other incidents. The service remains in breach of the two Regulations from our inspection in February 2018, Regulation 11 Consent and Regulation 12 Safe care and treatment.

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

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

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

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following this inspection, we wrote a letter of intent to the provider to seek reassurance on how they would mitigate the immediate concerns and risks to people. The response received did not initially alleviate concerns and we requested further information be sent. The provider has now provided an action plan on how they will address these concerns.

We have served a Notice of Decision against this location to impose urgent conditions. The provider is not allowed to admit any future people to this service without the prior agreement of The Care Quality Commission. Further to this, the provider must submit a monthly report detailing how they ensure the service people receive is safe. This includes information on risks, incidents and quality monitoring.

The service did not have a registered manager at the time this inspection took place. Two managers were in place and were planning to jointly register for this service. Both were available throughout this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The care service has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. This model of care at Rowde would not be registered if an application were to be received at this moment in time. Fifty percent of people living at Rowde were from out of county Local Authorities. This meant that some people were living long distances from their relatives. A lot of people living at Rowde had moved to this site when another large residential home in Devon run by the previous provider had closed.

People had not been protected against the risks of potential and alleged abuse from one person in the service towards other people living at Rowde. Although staff continued to demonstrate their knowledge of different types of abuse and what they should do if they suspected abuse, when incidents had occurred this had not been followed in practice. There had been a significant failing in how to manage situations of abuse and a culture at Rowde had developed which normalised incidents as daily occurrences. Some staff had stopped seeing some incidents as reportable and referred to events as 'just what certain people did.'

Risk assessments did not contain all the necessary information staff required. At this inspection we saw the provider had failed to take the required action to keep people safe. They had not followed the action plan submitted after the last inspection in February 2018. The service remains in breach for a second consecutive time. Two people at high risk of choking did not have support or risk assessments in place to manage this risk at night.

Staff were unclear about which incidents had to be reported. There was no systematic approach in reporting and managing incidents, this varied across the location. We found a number of incidents that had not been either recorded on the system or reported to management. These incidents included physical altercations between people where an injury was sustained and no medical help was sought, unexplained bruising, a person who had passed out with no medical attention called, unexplained blood found on a bedroom floor, and people being in pain and crying out. Following our inspection, we asked that investigations into these incidents were conducted. The provider has reported back that actions were found to have been taken in some of these incidents. Other incidents were found to be incorrectly documented by staff. For a small number of incidents, no further information on actions taken could be evidenced.

People's rights were not protected in accordance with the Mental Capacity Act 2005. At this inspection we

saw the provider had failed to take the required action to keep people safe and had not met this breach identified at our inspection in February 2018, as stated in their action plan. The service remains in breach for a second consecutive time. We identified that potentially 24 people were being deprived of their liberty unlawfully.

The provider's quality assurance systems had failed to identify the significant concerns in the service and action had not been taken to keep people safe. The quality tool did not consider all aspects within the service or monitoring checks that senior staff should complete. For this reason, there were significant gaps in the provider oversight of the service and the service people received. The managers, senior management and provider had no awareness of a large numbers of incidents that had not been reported to them.

At this inspection we found that the provider had failed to notify us of five alleged abuse incidents and two injuries requiring medical intervention. The management were unaware of these incidents and they had not been reported internally in line with the provider's protocols. This meant people had been left at risk of ongoing harm. Staff had lost a lot of confidence in the previous and current management team to take their concerns seriously and provide appropriate support.

The staff morale in the service was not good and was having a negative impact on the people being supported. Staff spoke of the effects of agency staff on the consistency of support provided to people, the conflicts between staff and the lack of faith and support they had experienced with management teams. Staff consistently spoke about feeling like they were working in isolation and there continued to be a disjointed service in terms of staff knowledge on the ground and the communication given to them from the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe.

People living at Rowde had not been protected against the risks of potential and alleged abuse. There had been a significant failing in how to manage situations of abuse and a culture at Rowde had developed which normalised incidents as daily occurrences.

Risk assessments did not contain all the necessary information staff required. Two people at high risk of choking did not have support or risk assessments in place to manage this risk at night.

Staff were unclear about which incidents had to be reported. There was no systematic approach in reporting and managing incidents. We found vast amounts of incidents that had not been either recorded on the system or reported to management.

We saw that agency staff did not have a planned induction to the service. This was left to staff across the bungalows to conduct rather than a universal approach being applied.

Is the service effective?

Requires Improvement

This service is not effective.

People's rights were not protected in accordance with the Mental Capacity Act 2005. We identified that potentially 24 people were being deprived of their liberty unlawfully.

Staff had continued to receive mandatory training and refreshers of this training relevant to their role. However, for some non-mandatory training not all staff received this. This included training on the online system to report incidents.

Each person had a health file alongside their care plan which recorded information about any specific health needs and the associated professionals involved with their healthcare.

Is the service well-led?

Inadequate

The service is not well-led

The provider's quality assurance systems had failed to identify the significant concerns in the service in order to keep people safe. For this reason, there were significant gaps in the provider oversight of the service and the service people received. The managers, senior management and provider had no awareness of the large numbers of unreported incidents that had occurred within the service

At this inspection we found that the provider had failed to notify us of five alleged abuse incidents and two injuries requiring medical intervention.

The staff morale in the service was not good and was having a negative impact on the people being supported.

Rowde

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.

The inspection was prompted in part by notification of an incident following which alleged sexual abuse claims have been made concerning people who use the service. The notification was reported by the service to The Care Quality Commission and the Adults safeguarding team. This incident is currently being investigated by the Adults safeguarding team. The Care Quality Commission are reviewing the information and considering what regulatory action to take.

This inspection took place on the 12, 13 and 18 July 2018 and was unannounced. At this inspection we conducted an urgent focused approach to ensure people living at Rowde were safe. We looked at three domains, safe, effective and well-led.

The inspection team consisted of two inspectors and a pharmacist specialist from our medicines team. We spent time speaking with and observing people who were using this service. We spoke with the two managers, two regional managers, one senior regional manager and the director of the south west division. We also spoke with 17 members of staff.

We looked at the care records of nine people and other records relating to aspects of the service including care, training and quality assurance.

Inadequate

Is the service safe?

Our findings

People had not been protected against the risks of potential and alleged abuse from one person in the service towards other people living at Rowde. Although staff continued to demonstrate their knowledge of different types of abuse and what they should do if they suspected abuse, when incidents had occurred this had not always been followed in practice. Staff had received safeguarding training and spoke about taking their concerns to the manager or externally. However, in practice they had failed to do this. This had left people at significant risk of potential and alleged abuse within the service. The Local Authority has been working with the provider to provide support in addressing the safeguarding concerns and further risks highlighted during this inspection.

There had been a significant failing in how to manage situations of abuse and a culture at Rowde had developed which normalised incidents of abuse as daily occurrences. Staff had stopped seeing some incidents as reportable and referred to events as 'just what certain people did.'

Staff spoke about losing faith in the previous management to manage safeguarding situations and did not believe concerns had been appropriately investigated or action taken to keep people safe. This meant some staff stopped reporting their concerns. One staff told us "I raised a safeguarding, I told my line manager and it's up to them what they do with it. You have to get used to the fact that you don't find out what the outcome is. Because you don't get feedback you can't be fully confident. I have had issues reported in past that were told were dealt with but the individuals are still here so gives me reason to know they weren't managed."

Comments from other staff included "I have the confidence to raise concerns but less confidence that they will be investigated thoroughly", "I did not have confidence to raise things with the previous management, I was not there for one safeguarding incident but I came back and they did nothing. I feel confident with the current management, I have more faith now than ever before", "We are not afraid to raise concerns, but we don't get the feedback or know the actions" and "Initially I discuss with my manager, make a call to safeguarding and make a record. I do now have confidence to raise safeguarding concerns, it's become clearer lately." The senior management were genuinely shocked by the lack of reporting in the service that had left people at risk of potential and alleged abuse with the director commenting "I'm worried that people have been left vulnerable."

We found that for one ongoing safeguarding incident there were pockets of staff within the service who knew about previous historical safeguarding concerns relating to this. This historical safeguarding concern was investigated when Rowde was registered to the previous provider. When we spoke with staff they were open about this and thought it was widely known within the service. We found evidence that a risk assessment had been in place for this incident, however management stated they were unaware of this and staff had not mentioned anything to them. One staff told us "An incident happened about five years ago. It was [person's name] there was a safeguarding incident with another person. There was guidance about that for us, we were to keep [person name] away from [person name]. There was a paper copy of this guidance." Another staff told us they actively ensured that two people were kept away from each other and remarked "I

don't know if other staff do this but I do, it all came from the safeguarding incident a few years back." This meant appropriate measures had not been taken to ensure people were kept safe from potential and alleged abuse. There had been no management oversight of this safeguarding incident and measures were not in place for staff to manage risks to others effectively.

Despite an ongoing safeguarding concern, the service had not taken enough measures following a safeguarding meeting to keep people safe. We found that measures such as a sensor alarm on a back gate had not been implemented. We raised this immediately with the service who said there had been a communication issue and they then arranged someone to attend that day. However, a near miss incident occurred following our inspection which demonstrated the concerns were still not being mitigated in order to keep people safe. We observed that during one to one support of a person, the staff member did not have them in their line of sight for a period of up to 10 minutes. The service were also using agency staff to help cover these one to one hours who had not received a proper induction to the service. One of the managers showed us they had emailed staff providing the one to one support with guidance 16 days after the incident occurred, however this email
evidenced that only nine out of 19 staff had read the email. Actions to mitigate the risks had not been implemented, in a timely, effectively manner or managed appropriately.

One staff told us "I am aware of the incident that happened years ago. We were not told anything, I am not aware of anything in place to prevent [person's name] moving around the site. There is no formal arrangement to prevent [person's name] but we are aware of an incident so it might be word of mouth."

One staff raised a previous safeguarding incident with us which had not been managed appropriately commenting "In hindsight we should have done things differently. I knew people were safe but I felt vulnerable. But it was tricky back then. [A previous manager name] was here and their family and friends all worked here. I feel able to go to the managers now but back then it was different. If you had supervision and raised anything it would get back, nothing was confidential and I was not able to talk about some staff as I should have." The director told us "I want to know why staff didn't feel they could take their concerns anywhere else. We are changing our safeguarding training to be a reflective practice, they will be given pre-training and then receive formal training."

The systems in place to protect people from abuse had not been followed and as a result people had been significantly failed and put at risk of abuse. Staff we spoke with were still unclear about the actions they were to take in supporting one person and guidance was not in place to guide them. The director told the management "We need to make this clearer. We need to do an awful lot of work with debriefing staff, and giving them scenarios. We are going to focus on making training personal, talk about individual people and ask do you think there is anything that you didn't report but should have." During our inspection two further disclosures of a safeguarding nature were made. The management are investigating and will report back to us when this is completed.

This was a breach of Regulation 13 (1) (2) (3) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in February 2018 the home had been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some risk assessments needed work to ensure they contained all the necessary information staff required. Medicines were not always being safely managed. A requirement notice was made and the provider submitted an action plan to say they would meet this breach by the end of April 2018. At this inspection we saw the provider had failed to take the required action to keep people safe and had not met this breach as stated in their action plan.

Some improvements had been made in medicines management, however the service remains in breach for a second consecutive time and we are currently considering enforcement action in response to this.

For an ongoing safeguarding concern, we saw that a risk assessment was not in place in one person's care plan for staff to have information to hand. The risk assessment had been completed but was in the office. We reviewed this risk assessment and saw that it did not provide sufficient information to mitigate the risk or the actions to take. This person's care plan had not been updated despite it being a matter of urgency and priority. We were informed that it was planned to be done the day of our inspection, nearly a month after the initial safeguarding meeting.

We saw that a staff signature sheet was put into care plans for staff to sign when they had read and understood the care plan and associated risk assessments. However, we saw most signature sheets only had one or two signatures on demonstrating how few staff had read each care plan. This meant not all staff would be aware of any changes that had been made if they had not been told by other staff. One staff told us "I signed the risk assessments, there was a big stack of them, one was about someone being full on and watching them around certain people." Other staff said, "We used to add risk assessments in the past ourselves, however the risk assessments have been updated by the seniors", "Seniors have been doing the risk assessment, previously support workers had done them. We find it hard to access the relevant information when needed, the current ones are better."

We saw that despite the risk assessments having been updated they did not contain enough detail specific to the individual or the action to take to manage the risk. The risk assessments were generic and had been recorded for everyone and not considered if there was an actual risk to the person concerned.

Risk assessments were given a low, medium or high rating by staff; however, it did not seem to be understood what categorised as a high risk as the majority of risks were all rated low. The system did not alert management to sign off the risks if they were not categorised as high, which meant they were unaware of the seriousness of some risks and how they were being managed. We raised our concerns with senior management who took action to contact the director of operations and request a manual change to signing off risk assessments. This would mean that only a manager could review and sign off any risk assessment rather than as is currently required to review and sign off high and medium risks. We further discussed that staff needed support in understanding what was considered a low, medium or high risk.

One person had a risk assessment for keeping safe which recorded they needed support at night from the sleep-in staff. It stated this person may knock too quietly on the staff door and not be heard by staff and due to communication needs were unable to make themselves known. The risk assessment stated the measures to take were that the person had a ground floor room, despite only bungalows being on the site and that they knew where the staff sleep in room was to knock if requiring support. This assessment had completely ignored the identified risk and not set any actions to mitigate this. This meant this person continued to be at risk of not being able to gain staff support if they needed.

We saw that two people were at high risk of choking and required full staff presence and support when they ate. However, there was nothing in place to manage this risk at night and both people were independent in their movements. We raised the risk of these two people accessing the fridge without staff knowledge and having a choking incident. Staff and management response was that they had never tried to do this before. One staff said, "I don't think [name of person] would go to the cupboards and help themselves but they are not locked." We saw an incident recorded in December 2017 where food packets were found in this person's drawers. It was documented by staff that "[name of person] told me they had eaten them, this was not the best thing for them to eat in private in their room. Advised against this in future." The care plan stated that

'Staff must be present at all mealtimes due to risk of choking.' This had not been followed and measures had not been put in place to reduce the risk of this person choking. This person had been exposed to harm. The risk was categorised as a low risk.

Some people living at the service could at times experience anxiety or heightened emotions. This could then lead to behaviours displayed that may be difficult for staff to manage and may place the person and other people at risk of harm. People had positive behaviour plans in place which varied in the level of detail and action staff should take. The plans documented how incidents should be clearly recorded on an Antecedent Behaviour Consequence chart (ABC), (An ABC Chart is a direct observation tool that can be used to collect information about the events that are occurring within a person's environment.) However, we could find no evidence of ABC charts being used and staff confirmed that they did not record behaviour events on these.

We saw that one person was supported by a member of staff on a one to one basis due to their behaviour needs. This person had a waking member of staff for four nights a week, however on the other nights there was only a sleep-in member of staff. The local authority had initially agreed to a waking member of night staff every night with the expectation that it would be reduced. The rationale for reducing the waking nights did not make sense as it could not be predicted when this person would be up and the sleep-in staff had been disturbed on occasions. This was having effects on the other people living in the bungalow and one person had already expressed a wish to move out. The director agreed the management of this currently made no sense. One staff told us "I think [name of person] was misplaced here, it impacts on the people living here, it's damaged the morale of the staff as has not been managed properly. We have had behavioural specialist come and give advice." We saw that the techniques given to staff had not been documented in this person's care plan for all staff to read and follow.

The management of the service told us that the people staff thought had challenging behaviour was not really what they considered to be challenging. However, we saw one person's care plan recorded verbal and physical aggression could be shown. We saw an assessment from the Local Authority completed in January 2018 stated that physical aggression had been shown to other people this person lived with and that urgent behavioural intervention and advice was required to prevent breakdown of the placement in light of the strain placed on staff and people in that bungalow. A positive behaviour plan was in place but there was no risk assessment or monitoring documentation around incidents for this person. This meant the management were not fully aware of the extent of this person's behaviour in order to provide the appropriate support.

Another person was at risk of self-harm due to their mental health condition. There was nothing documented in the care plan about this and no risk assessment or protocol in place to support this person effectively. We saw an entry from senior staff to staff in the communication book reminding staff to 'keep [name of person] busy as if upset this is very serious and if it isn't taken seriously it is neglect and abuse and could lead to disciplinary investigation'. We saw that there had been an incident that left this person at significant risk but the management were unaware of this as it was not reported or recorded on the system. We saw this person's care plan had been updated in June 2018, however, nothing around this had been included. This meant this person was at risk of harm as no guidance was in place for staff to follow and action was not being taken in a timely manner.

Staff told us they struggled to manage incidents effectively in the service and did not always feel supported to do this. Comments included "I have had training but you need to know them. Knowing them is better than training. If I went to work in a different bungalow I wouldn't know the people. I don't have time to read care plans. New faces can cause anxiety. It is more difficult at the weekend, we struggle to cover shifts.", "There has been an incident where information was not shared between staff and we were left to deal with a

situation that I was not comfortable with" and "There are occasions when staff do deal with things themselves around behaviour. We do encourage them to report so we can support." The director told us "We need to have a look at people who have behaviour needs and should have positive behaviour support plans and see if there are any gaps. We will refer to our internal behaviour team to also come out and do assessments and work with people on this site."

The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. We looked at the behaviour incidents that staff had been recording for people and saw these were kept in a communication book in each bungalow. We cross referenced these incidents on the provider's electronic incident reporting system and found they had not been logged. Further to this the management were not aware of all of these events that had been managed in isolation by staff. This meant there was a lack of management oversight of what incidents had occurred, how they were managed and the true extent of people's behaviour. This meant the appropriate action and support had not been provided in a timely manner to support these people and people and staff had been left vulnerable.

Staff were unclear about which incidents had to be reported. There was no systematic approach to reporting and managing incidents, this varied across the location. Some staff would record on the electronic system whilst other staff wrote it on paper, or in a communication book. Other staff told us they did not like to use the computer system, did not know how, or did not get time to do so. The communication books were not part of any checks by seniors or management which meant there was no oversight to the incidents that were happening within the service. It was clear from discussions with staff that each bungalow had their own threshold for reporting incidents.

Staff told us "We make a judgement call about individual incidents, if it's serious we put it on the system", "I'm not happy with the way things are recorded. I call the manager and tell them. We have a computer system but not all staff are comfortable with it and have no idea how to use a computer. Some people just call the manager, get a colleague to do it or do it on paper", "I put incidents in the communication book, not to my knowledge do we put them anywhere else", "I record incidents on the system for behaviour. Last week someone was shouting at someone else so I recorded it online, no one told me to do that, but I just do" and "There is an online system for incidents, some staff do struggle with these and there are paper copies and then we ask they are logged on system."

We looked at the communication books for two bungalows and found vast amounts of incidents that had not been either recorded on the system or reported to management. These incidents included physical altercations between people where an injury to their head was sustained and no medical help was sought, unexplained bruising, a person who had passed out with no medical attention called, unexplained blood found on a bedroom floor, and people being in pain and crying out. Following our inspection, we asked that investigations into these incidents were conducted. The provider has reported back that actions were found to have been taken in some of these incidents. Other incidents were found to be incorrectly documented by staff. For a small number of incidents, no further information on actions taken could be evidenced.

We spoke with staff about some of the incidents that were recorded and they were unaware of investigations taking place after these. One staff told us "I am aware of one incident with a person, I am not sure if I was told or I saw it written somewhere. The problem is with seven people there is a lot going on. The system is still so new we are getting used to putting things on there and there isn't always time to sit and do it. It could take an hour and the people need us. We have had some training on it but we could do with more, I know this incident should have been logged on system."

The management and senior management were all unaware of the majority of incidents we raised with them. The protocols and policies for reporting and investigating incidents had not been followed. There was no documented evidence of actions taken after incidents and it became clear that action had not happened above individual staff level. The provider's quality monitoring had failed to pick up that not all incidents and accidents were not being reported. This meant that people had been left at significant risk of harm and ongoing harm due to failure to act and keep them safe and put measures in place to mitigate risks.

We looked at the medicine administration records and associated medicine care plans for 26 people. Staff administering medicines had received training and been assessed as competent to carry out the task. There were signature sheets to confirm this within each person's medication administration record (MAR), however some of these sheets were incomplete.

Medicines were stored securely in people's individual medicines cupboards or within a central medicines cupboard in the staff sleep in room. In some of the bungalows the storage arrangements had been amended due to the warm weather being experienced at the time of inspection. It had been identified that the temperature of some individual cabinets was above 25 Celsius. In one bungalow they had addressed this by placing ice packs in the individual's cabinet. In two of the bungalows they had removed the medicines to a central location and placed ice packs in the central cabinet. In the fourth bungalow although the temperature had been recorded there was no record of any action taken to keep this within the recommended range. This meant the medicines were not being monitored safely and could become ineffective to use if suitable temperatures were not maintained.

Care staff signed MAR's after giving medicines. We found that staff had added some entries to these charts but they had not always done so in line with the provider's policy. These entries contained the information from the pharmacy dispensing label. The provider should review how they monitor completion of charts and the actions taken when policy is not followed.

Where people were prescribed topical medicines, there were body maps present to show care staff where these should be applied. Most of these were clear. We saw for one person the directions for administration indicated that the gel could be applied to different locations. These different locations were recorded on the body map; however, the MAR did not record which location they had been applied to. Staff were able to tell us that the gel was applied regularly to one area and to other areas at the request of the person. They confirmed that they did not document this. We raised with this the management to address.

Some people had medicines prescribed to be taken when required. We saw that there were specific plans in place to inform staff how to use these medicines to support the person. The information did not always reflect the information in the person's risk assessment. This was particularly in relation to medicines prescribed to support people with health interventions. Staff were able to tell us how and when these medicines were to be used. The provider was conducting monthly audits on the storage of medicines and completion of associated records. The audits had identified some of the issues that we observed, but did not always specify the action to be taken.

This was a breach of Regulation 12 (2) (a) (b) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had continued to struggle with recruiting permanent members of staff since our last inspection in February 2018.This was due in part to the rural location of the service and financial competition from other care providers. The service relied on agency staff to cover shifts on a regular basis and on some occasions, we saw over 300 hours in a week, had been filled by agency staff. A director of the service told us

"We have raised this with the local funding authority with the aim of increasing staff pay. It does struggle financially. It is getting critical in terms of recruitment, we are competing with the financial market for wages. We do have our eye on this site, we have not been complacent."

Staff told us despite having regular agency staff it did increase the pressure they felt and had an impact on the consistency people experienced. Staff commented "Not enough staff, they are starting to do new rotas as things are all over the place at the moment. If people have no independent travel we struggle for people to go out. Sometimes things have had to be cancelled as there is only one member of staff, but the people are understanding", "We have not got anywhere near the staffing we should have and it puts additional pressure on the staff and the people we support notice, we have agency a lot. One person takes advantage of certain situations, if with agency they will take advantage. Staffing isn't a criticism of management it's a fact, they have tried recruiting" "It's a demanding job for people who are paid a minimum wage" and "Staffing is awful, the reliance on agency affects the consistency for people with a learning disability. They need reassurance."

Agency staff did not have a planned induction to the service. This was left to staff across the bungalows to conduct rather than a universal approach being applied. One agency staff told us they had not received an induction and did not know what action to take in the event of a fire. This person was providing one to one support with a person who had complex behavioural needs. The agency staff had not yet read this person's care plan or risk assessments and was unaware of certain behaviours that posed a risk for this person. This meant the person and the staff were in a vulnerable position which had not been managed effectively. The staff told us they had been assigned to support this person for a shift of over 11 hours straight.

The director told us that there was an agency induction checklist which should be completed for all agency staff coming to the service. One of the managers told us they could not confirm that this had been completed for all agency staff.

Four of the five bungalows were kept clean and tidy and had no detectable odours. However, one bungalow required maintenance and redecoration to ensure it remained a pleasant place to live. We saw the carpets were worn and heavily stained in some parts of this bungalow. We observed that staff wore appropriate personal protective equipment when needed and had access to stocks of cleaning equipment, gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

People's rights were not protected in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

At our last inspection in February 2018 the home had been in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the documentation in place for people who lacked capacity was not correct. A requirement notice was made and the provider submitted an action plan to say they would meet this breach by the end of May 2018. At this inspection we saw the provider had failed to take the required action to keep people safe and had not met this breach as stated in their action plan. The service remains in breach for a second consecutive time and we are currently considering enforcement action in response to this.

We identified that two people were unable to leave the site unless they had full staff support. There was no Mental capacity assessment in place for this and no DoLS application had been made. Staff told us if either of these two people tried to leave they would have to go with them or stop them as they were not considered to be safe in the community alone. We spoke to the management about these people and they had failed to understand the restrictions that were being imposed. We looked at everyone else at the service and found that in total 24 people were potentially being deprived of their liberty unlawfully as were not free to leave this location without staff support.

One person's risk assessment completed in May 2018 stated the person had a capacity assessment which had proven they lacked capacity to make an informed decision around care and support. However, there was only a capacity assessment for finances in their care plan and staff were unaware of a further one. Another person had a generic MCA put in their care plan which contained the names of the other people they shared a bungalow with. This was encroaching on other people's confidentiality and was not specific to the individual. One person had a relative that they were very close to and was involved in their support plan, however they had not been asked to be part of the MCA decision which had only included a staff member.

The director told us "We are still aware that we have loads to do for MCA. The action plan sits with the regional manager and managers and the dates for this are decided, however they were ambitious." We were told on the last day of our inspection an MCA toolkit was to be put in place to help staff understand how to complete assessments and how to ask people the questions around this.

This was a breach of Regulation 11 (1) (3) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had continued to receive mandatory training and refreshers of this training relevant to their role. Staff gave mixed reviews about the training commenting "The training is amazing here, they keep you interested, doing activities and we are spoken to if management think we need to go on a refresher courses. It is retained as we do it daily" and "We get a lot of training, some staff don't think it's very good, but I do", "I have online training, I have done higher level training. I prefer face to face training, HFT do everything online. They do moving and handling, first aid face to face and we did a report writing one face to face. Safeguarding is common sense, I have done my moving and handling and I am experienced in care" and "I enjoy my job, if I could change anything it would be to give the staff more training on promoting independence. Sometimes they do too much for people and don't let them do things themselves."

We saw that for some non-mandatory training not all staff had received this. This included positive behaviour management and training on the online system to report incidents. The training matrix recorded that 100% of staff had completed positive behaviour management training, however only 30 of the 60 staff had been assigned. The regional manager explained that staff are assigned where there is a need, so if they work alongside a person with behavioural needs they will be assigned to the training. However, there were people with this need in four of the bungalows and staff worked across the bungalows.

Only 21 out of 60 staff had completed training on using the system to report incidents. We asked how this worked for staff needing to record incidents and it was explained that other staff would be shown by a colleague how to use the system. This was not robust practice as staff who had received the training had told us they were not confident in using the system and we identified large numbers of incidents that had not been reported. The regional manager told us that after the inspection there would be a lot more staff assigned to receive this training. The director told us full training would soon be rolled out around the electronic system to all staff.

We spoke to one of the provider's internal trainers who told us their focus was on making sessions interactive for staff to aid learning. The trainer would have conversations with the managers if they felt staff required further training in a particular area.

We looked into the training that staff received around safeguarding to understand why they may not have been applying this knowledge in practice. The trainer explained that the safeguarding training was written in partnership with a leading UK authority on safeguarding adults and children with disabilities. A recent safeguarding training session had asked staff to write about anything they had seen that might fit examples of abuse. The trainer told us they then invited the managers to come and view what had been written stating there had been "No real concerns."

We observed that people were supported to have a meal of their choice. Some people were also involved in the preparing of food with staff support. The meals we observed looked fresh and appetising and people told us they enjoyed the food available.

Each person had a health file alongside their care plan which recorded information about any specific health needs and the associated professionals involved with their healthcare. We saw evidence of people being supported to see a doctor and attend health care appointments when required.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection there was not a registered manager in place. Two managers were jointly managing the service and were in the process of registering. At this time due to the concerns CQC have placed a hold on new registrations for this service.

The two managers currently in place had been recruited externally to the service. There had been a historical pattern of recruiting managers from within Rowde and this had contributed to some of the concerns around staff conflict and reporting incidents effectively. There were two previous registered managers working within Rowde as support staff at the time of this inspection. One manager told us "Historically the registered managers have de-registered and gone down to a care staff. One said they couldn't be doing with the stress. This is why I think we have been brought in from the outside."

The managers were supported by a regional manager who visited the service on a weekly basis. A new regional manager was also present at this inspection as they would be taking over this location shortly. The director told us "When HFT took over it was a whole process of doing the transformation of service, we had a team to introduce the policies to staff. There have been performance management amongst previous staff if they could not meet expectations and requirements of the role. It has been hard for some of the existing staff to meet the level HFT require."

The provider's quality assurance systems in place had failed to identify the significant concerns in the service in order to keep people safe. The managers would complete a self-assessment tool within the service and this would be checked by the regional manager. However due to workloads this had not been effectively checked in recent months and was not a true representation of what was happening in the service.

The quality tool did not consider all aspects within the service or monitoring checks that senior staff should complete. For this reason, there were significant gaps in the provider oversight of the service and the service people received. The director told us "The managers do a self-assessment which is part of the audit process. We have been putting efforts into developing a new system. I feel it lets us down as does not consider the whole customer journey. Regional managers are meant to check the managers self-assessments, but because of workload have not always had time to do this.

The managers, senior management and provider had no awareness of the large numbers of unreported incidents that had occurred within the service. The director confirmed that "Our quality assurance would only pick up what had been put on the system for accidents and incidents, not what is in the communication books as these were not checked. This is going to be operational process now." We saw that seniors spent the majority of their time in an office in the main building rather than in the bungalows. Senior management told us this had been identified and would be addressed to ensure the bungalows had effective leadership by example and senior presence. The director confirmed "Seniors are going to have training about what they need to be checking. A checklist is out in place today, there used to be a checklist in place but it fizzled out. Every level will know what they are checking, we are going to make a recommendation to senior level management that they undertake additional sampling."

A quarterly check of standards at one bungalow had been completed by senior management. On the 17 May 2018 they noted that the weekly health and safety checks were out of date, the fire drill was missing and the lone worker checklist was missing. There was no action plan or follow up of these points. The weekly health and safety checks had last been completed on the 5 June 2018. The managers monthly inspection of standards noted that on the 12 February 2018 staff needed to be reminded to do the weekly health and safety checks, on the 10 April 2018 the manager noted that the weekly checks had not been done. The provider quality systems had failed to manage concerns that were identified and take the appropriate action in a timely manner. People had been let down by the systems that were in place to keep them safe.

Since our last inspection in February 2018, an action plan had been sent to meet the breaches of Regulation. The provider had stated they would meet these breaches by the end of May 2018. However, we found the provider had failed to do this and remained in breach. There had been no consideration to checking the dates set to ensure they were realistic and no checking to ensure they had been completed appropriately. One staff told us "We have had a shocking CQC inspection rating and we know there is work to do."

We saw that staff across the bungalows were completing daily logs. However, these varied in appearance, detail of information and frequency of completion. The management were unaware of this difference between the bungalows and these records had not been routinely checked. The director informed us there were standard provider templates available which should have been used. However, this had not been enforced in the service. We spoke to the management about how staff are encouraged to follow good practice and were told "Good practice documents go out and it is up to individual managers to take them up." This meant there was not a consistent method in ensuring staff had opportunity to improve their practice.

This was a breach of Regulation 17 (2) (a) (b) (c) (f) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The director told us they were committed to fixing the concerns identified. A new quality tool was about to be trialled at Rowde. We observed this tool which was more structured and detailed following CQC's Key Lines of Enquiry (KLOES's). A senior regional manager told us "The new compliance system is clearer and purely based on the KLOES. It is a new one that will be implemented, it has not been signed off yet, but is in the process of being constructed and trialled." The director told us "Everything we are now giving to staff has completed examples so they know what we want."

Services are required by law to send us statutory notifications about incidents and events that have occurred at the service and which may need further investigation. At this inspection we found that the provider had failed to notify us of five alleged abuse incidents and two injuries requiring medical intervention. The management were unaware of these incidents and they had not been reported internally following the provider's protocols. This meant people had been left at risk of ongoing harm. We checked two of the five communication books where incidents were recorded. We asked the provider to check all the five books and report without further delay any further incidents that are notifiable to The CQC and to safeguarding. Following our inspection, we asked that investigations into these incidents were conducted. The provider has reported back that actions were found to have been taken in some of these incidents. The provider has now begun the process of making the outstanding historical notifications to CQC.

This was a breach of Regulation 18 (1) (2) (a) (b) (e) Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

The staff morale in the service was not good and was having a negative impact on the people being

supported. Staff spoke of the effects of agency staff on the consistency of support, the conflicts between staff and the lack of faith and support they had experienced with management teams. One staff told us "The morale is good here in [name of bungalow], we are a good team. But personalities clash in other bungalows. I know that [name of bungalow] is worse, the staff are at each other's throats over there." One manager told us "A previous manager had a lot of friends amongst the staff. Lots of staff are related or have connections outside of work. Some staff have been here a long time and some of them have held on to their old ways of working." The other manager said, 'Staff issues were identified in my interview."

Staff consistently spoke to us about feeling like they were working in isolation commenting "Morale is not very good at the moment, there are undercurrents. Staff think it takes a long time to get anything done so staff are frustrated", "Staff morale its hit and miss, it varies by staff teams in bungalows", "We have had some conflicts in the staff team", "The culture here with the previous management, things weren't being dealt with as they would be in other companies", "The culture in the individual bungalows is too clicky, the groups are too friendly, I think we need to move staff around as there is a lot of friends and relatives here" and "There has been improvements but the staff in individual bungalows get precious about the bungalow and don't do what is asked of them. People used to be more accountable back then, now they rely on seniors and managers too much."

The culture for people living at Rowde had elements of a paternalistic nature. There was an emphasis from staff around telling people to say please and thank you despite people being adults. Care plans alluded to people needing to apologise after incidents, for example one entry recorded "I am best left alone to calm down. I usually go to my room and work things out and then usually apologise." One of the managers told us "Local agreements had previously been in place, people were only allowed two pints of beer etc., this has now been taken out of care plans following the last inspection."

There continued to be a disjointed service in terms of staff knowledge on the ground and the communication given to them from the management team. Staff felt they often were not equipped with information necessary to fulfil their role, which impacted on the people they supported. Staff told us "We use email to communicate with management, it is not ideal but it is a record of what you have asked for. It has not always been like that", "Communication is quite poor, I have constantly said the communication is poor. There have been some improvements that show the organisation is listening", "The management is the less good part of this job, this management are not as good at implementing risk assessments, investigating safeguarding and responding to us, it's frustrating. This is true of previous and current management" and "We don't always get informed of stuff that is going on, if something was going on in [bungalow name], I would know but I don't always get told about other bungalows."

Staff had lost a lot of confidence in the previous and current management team to take their concerns seriously and provide appropriate support. One staff told us "The new management have come in here, but they have got a lot to learn. They have to get to know everyone and find things out over time. It used to be a manager in each bungalow. Now there is only two managers in the main building and it isn't enough. Staff can get lazy and not do stuff, the seniors are not out of the office, they are run off their feet. Things did used to be different. Things need to change. People are the centre of what we do, everything should be their choice, it is their home at the end of the day." Another staff commented "Some of the time I feel supported but not all the time."

There had been a lapse in staff involvement with the direction the service was going in. Staff referred loosely to the visions and values but were unable to explain these or demonstrate how they were relevant to daily life. Staff commented "We were told about the visions and values at our interview but this was not continued, we have that general ethos", and "Nobody has spoken to me about the visions and values. I want

to move forward with the people here. HFT don't involve us much. Years ago, we had [staff name], they were really good and told us everything. We are not always informed. We used to have general meetings in Marsh Hall with minutes, but that has stopped."

We saw that meetings with staff and people were held in the individual bungalows by the seniors. The seniors would then debrief the managers on any actions. It was hard to obtain copies of previous meeting minutes, there was no copy kept by the managers, instead seniors had them on their computers or in a file. We reviewed some of these and saw that in a six month period the same issues were being raised consistently with no evidence of actions taken. This did not demonstrate that concerns were being listened to or dealt with in an effective way. One manager told us "We need to instil trust in the management by being visible, by staff seeing action is being taken." One regional manager told us they planned to start up a working party at Rowde, inviting staff to resolve issues and drive positive responses.

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 18 Registration Regulations 2009 Notifications of other incidents At this inspection we found that the provider had failed to notify us of five alleged abuse incidents and two injuries requiring medical intervention. Regulation 18 (1) (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not protected in accordance with the Mental Capacity Act 2005 (MCA). We found that 24 people were being deprived of their liberty unlawfully as were not free to leave this location without staff support. Regulation 11 (1) (3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not contain all the necessary information staff required. Where a risk was identified a risk assessment had not always been put in place. Staff were unclear about which incidents had to be reported. There was no systematic approach in reporting and managing incidents. We found vast amounts of incidents that had not been either recorded on the system or reported to management. Medicines were not always safely managed. Regulation 12 (2) (a) (b) (g)

The enforcement action we took:

We have served an Notice of Decision to vary a condition of this providers registration.

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 People had not been protected against the risks of potential and alleged abuse in the service. There had been a significant failing in how to manage situations of abuse. Staff did not believe concerns had been appropriately investigated or action taken to keep people safe. This meant some staff stopped reporting their concerns. Regulation 13 (1) (2) (3)

The enforcement action we took:

We have imposed conditions on the provider's registration.

No new service users can be admitted to Rowde without the prior written agreement of the Care Quality

Commission.

The provider must provide a written record of all incidents and accidents and action taken to mitigate the risk of reoccurrence. Audits must be undertaken at least once a month of all service users' care plans, risk assessments, behaviour plans, communication books and of all quality monitoring.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People had not been protected against the risks of potential and alleged abuse in the service. There had been a significant failing in how to manage situations of abuse. Staff did not believe concerns had been appropriately investigated or action taken to keep people safe. This meant some staff stopped reporting their concerns. Regulation 13 (1) (2) (3)

The enforcement action we took:

We have served an Notice of Decision to vary a condition of this providers registration.