Alphonsus Services Limited

Charles House

Inspection report

257 Birchfield Road
Perry Barr
Birmingham
West Midlands
B20 3DG

Tel: 01213314972

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Charles House is a care home that is registered to provide care for up to 10 people who have a learning disability. At the time of our inspection 6 people were living at this home. At the last inspection on 30 January 2015 the service was rated good. This inspection identified that the quality and safety of the service had not been maintained. Our inspection identified six breaches of the legal regulations. (Health and Social Care Act 2008) We have taken action to protect people, and we have rated the service as inadequate. We have told the provider that further urgent improvements are needed to ensure the service people receive is safe, that it meets people's individual needs and is of a good quality. Full information about CQC's regulatory response to the more serious concerns found during inspections is added after any representations and appeals have been concluded.

There was a registered manager in place at the time of our 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.

People did not always receive the support they required to maintain their safety and well- being. Some incidents of harm had occurred including people being touched inappropriately. These incidents had not been identified as potential sexual abuse and subsequently they had not been reported to the relevant agencies. The people involved had not received the support they required to keep them safe and to stop further incidents occurring. There were enough staff to support people with their personal care and day to day life, however the delegation of staff wasn't adequate to ensure that people were kept safe. The registered provider had undertaken robust recruitment checks to ensure that new staff were suitable to work with people.

Risks relating to people's healthcare needs and lifestyle had not all been assessed, and the action needed to manage and reduce the risk had not always been identified or planned. Staff we spoke with gave inconsistent accounts of how they supported people and the support was not always consistent with good practice guidelines. Action had not been taken to review the incidents that had occurred to ensure that people's support plans were adjusted and action taken to reduce the likelihood of the incident happening again. In the area of risk management the registered provider and registered manager had not done all possible to ensure the likelihood of the risk reoccurring was as low as possible.

People required the support of staff to manage their medicines. Staff responsible for administering medicines had been trained and assessed and we found that people received their medicine when they needed it.

People were supported to see a wide range of health professionals, however some of the specific health needs people lived with had not been care planned, and not all specialist appointments had been attended. Staff we spoke with knew people well, and were able to identify changes in people's wellbeing. People were

provided with a wide range of meals and drinks that they enjoyed and that would ensure they maintained good hydration and nutrition.

People were supported to have some choice and control of their lives. We observed some examples of good practice, and some occasions where the opportunity to involve the person more had been missed. When restrictions on people's liberty were necessary the registered manager had ensured the correct applications had been made to protect each person's legal rights.

In our discussions staff demonstrated that they cared about the people they supported and many of the interactions we observed supported this. However some of the care we observed was focussed on the tasks to be completed and not the person. The care provided did not always protect and promote the person's dignity. Staff had failed to protect people and taken action to uphold their human and legal rights. The staff we met knew people well, and were able to tell us about people including their needs, preferences and things and people who were important to them.

A range of activities and opportunities were provided for four of the six people each day. This meant these people were supported into the local community on a regular basis. The activities offered and undertaken were not specifically tailored or planned to meet each person's needs and preferences. Two people with more complex care and support needs had far fewer opportunities and the registered manager and registered provider failed to demonstrate that they had the skills to provide a more specialist service for people with this additional level of needs. People had been supported to maintain links with people that were important to them.

There was little evidence of people being involved in the planning of their care; however relatives and staff that knew people well had been. The knowledge of the person's wishes and lifestyle was used to plan care that they felt was in the person's best interest and best fitted their known preferences and wishes.

The home was not consistently well run. During our inspection we identified numerous and serious issues including potential abuse of a safeguarding nature. The incidents recorded had not been identified as safeguarding issues by the registered manager or provider. They had not taken the action required to protect people, to escalate the concerns, or to ensure the relevant professionals were involved. The inspection identified six breaches of the legal regulations that providers are required to comply with. This meant people were receiving a service that was not safe, did not meet their needs or comply with the requirements of the law.

It was apparent that the registered manager had made improvements to the environment since they had started work at the home in September 2016. People and relatives we spoke with gave us positive feedback about the manager. The staff we spoke with shared mixed feedback about the manager. We shared these concerns with the registered provider for further consideration. The inspection identified that there was no clear plan on how to progress and improve. The checks on the safety and quality of the service had not been effective. The checks had not ensured that the service remained good, or that the service was meeting people's needs and all of the fundamental standards.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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 was not safe.

People had been exposed to potential abuse. This had not been identified and action had not been taken to protect people or to reduce the likelihood of this re-occurring.

Risks people lived with had not all been assessed, or planned to ensure that people received the support they needed to stay safe. Action had not been taken to reduce as far as possible the likelihood of the risk re-occurring.

Staff had received training in safeguarding, however people could not be confident that staff would always identify incidents that should be identified and reported as safeguarding.

People were supported by adequate numbers of staff to meet their personal care needs, however there were not always enough staff in the right place to keep people safe. Staff had been subject to robust recruitment checks.

People could be confident their medicines would be administered safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to see a wide range of health professionals. However not all healthcare and support needs had been planned. This did not ensure people got care and support that had been planned in line with best practice to maintain good health and to meet their needs.

Staff had been provided with training, however this had not always been consistently applied to their practice.

Systems were in place to ensure deprivations to people's liberty were identified and that the appropriate applications made to the supervisory body. Staff did not all offer people choices.

People enjoyed the food and drinks that were prepared and served in the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not work consistently to ensure people could be confident that their dignity would be maintained.

People were supported by a consistent team of staff that they trusted and knew well.

People's received support to maintain their culture, religion and gender.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported in a way that reflected their individual needs and wishes. Opportunities for people to be involved in planning and reviewing their care were limited.

People did have the opportunity to undertake activities. These were not always based on their interests or hobbies.

There was a complaints procedure in place, and relatives reported feeling confident to approach the registered manager.

Is the service well-led?

Inadequate

The service was not always well led.

The systems in place to ensure people consistently received a good and safe service had not been effective.

Notifications that are legally required had not been made as is required.

There was a registered manager in place, about whom the majority of feedback was positive.

Charles House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 01 and 31 August 2017 and was unannounced. The inspection was undertaken on the first day by one inspector and an expert by experience and on the second day by one inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection visit we reviewed all the information we held about the service, and contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information from notifications to help us determine the areas we wanted to focus our inspection on. The registered manager had completed and returned a Provider Information Return (PIR). This informed us of how the home was operating and any improvements they planned to make in the next 12 months. We used this information to help us plan our inspection.

We visited the home and met everyone currently living there. Three people spoke with us. Some of the people living at the home were not able to speak to us due to their health conditions and communication needs. We spent time in communal areas observing how care was delivered and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with five care staff, and the registered manager. We looked at parts of two people's care plans. We looked at the systems in place to check medicines were managed and administered safely. We looked at the recruitment records of two staff. We looked at the checks and audits undertaken by

the registered manager and registered provider to ensure the service provided was meeting people's needs and the requirements of the law. We spoke with three relatives.

Inadequate

Is the service safe?

Our findings

We last inspected Charles House on 30 January 2015. At that inspection we found that people were safe and rated the service as good. This inspection identified that the quality and safety of the service had not been maintained. We have rated this key question as Inadequate as people were not safe, and overall six legal regulations had not been met.

People were not always safe. One person whose care we looked at in detail had been repeatedly touched by other people living at the home. This had not been identified as potential abuse or as a safeguarding matter. Records showed that this touching occurred numerous times each day. Records about this touching had been commenced in December 2016, which provided evidence this had been taking place for over eight months. The incidents had not been reported to the police, the local authority safeguarding team or the Care Quality Commission. This meant the people affected had not always received the support they required, and the relevant authorities had not been notified.

Staff we spoke with confidently described the action they would take in the event of abuse being reported or alleged. One member of staff told us, "If I found bruising that I couldn't explain I would make sure I body mapped it. I'd tell the senior or the manager." [Body mapping is an accurate way of recording the location on a person's body of an injury.] The member of staff went on to show us where the required documents were located. The registered manager understood the process for reporting safeguarding incidents involving people who lived at the service. However only one of the staff we spoke with identified the ongoing touching of people as a safeguarding matter. The member of staff explained that they did not feel empowered to raise this as safeguarding and was fearful of the consequences. The knowledge staff had been provided with in training had not been put into practice. On August 01 2017 we requested the registered manager to make a safeguarding report and to take action to ensure people affected were safe, and that the person undertaking the abuse received the support they required. When we returned to the home for the second part of our inspection we found that the situation remained unchanged. Failing to safeguard people from the risk of abuse and to operate effective systems and processes that would ensure these incidents are identified, investigated and acted upon is a breach of the Health and Social Care Act 2008. Regulated Activities Regulations 2014. Regulation 13.

Risks associated with people's needs had not all been identified and assessed. The way that staff provided support when people presented with a risk was inconsistent. Some people living at the home displayed behaviours as a means to communicate their feelings or as a way of requesting support. Staff we spoke with were able to describe what the person was communicating when they displayed certain behaviours. The staff we spoke with described the way they supported people when their behaviour was unsettled. However the support described was inconsistent and was not always reflective of current good practice guidance. The care records we viewed did not include a positive behaviour support plan, which is a way of helping the person meet their needs and that reduces the likelihood of certain behaviours and events occurring. The risks relating to people's behaviour had been known to the registered manager when the person moved into the home, however they had not been assessed, and when the behaviour occurred it had not been usefully recorded. The eight months of behaviour records available had not been used to analyse the incidents, or to

establish when and possibly why they had occurred. It was not possible to track which other people had been involved or affected by the behaviour. Improving this recording would help the registered manager review and adapt the person's care to reduce the likelihood of these incidents re-occurring. The registered manager had not followed good practice guidance, and had not taken action to ensure the likelihood of the events reoccurring were as low as possible. This is a breach of the Health and Social Care Act 2008. Regulated Activities 2014. Regulation 12.

The people we spoke with told us they were happy with the service provided and had no concerns for their safety or well-being. Relatives of people living at the home confirmed they had no concerns regarding people's safety. One relative told us, "My relative is 100% safe. I just know." Another relative told us, "Sometimes I visit unexpected, and it is exactly the same as if I'd rung and let them know I was visiting." Throughout our inspection we observed people looking relaxed and calm with the staff that supported them.

The staff we spoke with described some of the actions they took to ensure people remained safe. This included ensuring that the front door was locked, that people were not given food or drink that would burn them and supporting people when they were out in the community. Relatives told us that they felt confident the home was a safe place for their family member to live. One relative told us, "There are fire doors, rails, the staff are always around. [Name of person] is never left alone and is checked at night time." Records we looked at showed that the safety equipment in the home including the fire alarm, and the electrical and gas equipment had been serviced and inspected as is required. Staff we spoke with confidently described the action they would take in the event of a medical emergency. This helped to promote people's safety and would ensure that people received prompt first aid and medical treatment.

Our observations, discussions with people, staff and relatives showed there were sufficient numbers of staff on duty to meet people's personal care needs and help them with day to day life. However the delegation of staff was not enough to ensure that people were safe. Any staffing shortfalls were covered by staff already working at the service to ensure people were supported by staff that were familiar with the service and people's needs. One relative told us, "There are always staff around; there is always a staff in each room."

The staff team were established and no new staff had been recruited recently. Records we looked at showed that the provider had robust recruitment practices to ensure staff employed were safe to support people. These checks included obtaining a Disclosure and Barring Service Check (DBS) and securing references from past employers. This helped to ensure people were supported by staff suitable to work in adult social care.

People could be confident that their medicines were well managed. Staff who administered medication had been trained and assessed as competent to do so. Staff we spoke with consistently described the process they followed to ensure medicines were safely administered and managed. One member of staff told us, "We get trained to do this safely, and checked to make sure we are competent." Records showed that medicines had been given as prescribed. We saw checks were undertaken by a designated member of staff to ensure people had received their prescribed medicines. We identified that the system to ensure medicines that were no longer required, needed to improve to ensure these were safely removed from the home and destroyed.

Requires Improvement

Is the service effective?

Our findings

We last inspected Charles House on 30 January 2015. At that inspection we found that people were receiving effective care and support and rated the service as good. This inspection identified that this position had not been maintained.

People had been supported with their primary health care, and records showed that people had been supported to access the GP and dentist for example when they needed this or requested it. Staff described how their long standing knowledge of people helped them to identify changes in people's healthcare needs. One member of staff told us, "We know people well, so we notice small changes in them." One of the people whose care we looked at in detail had an ongoing healthcare need. While we did not find evidence that this condition had not been well managed, there was no plan of care that set out the care and support needs the person had in relation to this condition. Records were not available to confirm that all of the specialist healthcare checks had been offered to the person. The absence of a care plan and clear records regarding this condition placed the person at increased risk of not receiving the best possible healthcare.

Staff had regularly weighed people. However there was no care plan that identified for each person what a healthy weight would be. We saw that one person had gained a significant amount of weight since moving into the home. There was no evidence that they had been helped to identify this, or to take action towards making healthier lifestyle choices. Staff did not know if people needed support to maintain, increase or decrease their weight.

One person had support needs in relation to managing some habits and behaviours that impacted on both them and others. This area of support had not been assessed and no written plan had been developed. Good practice guidance directs care providers to address these needs within positive behaviour support plans. The registered manager was not aware of these, and a plan that reflected these principles had not been developed. Staff we spoke with described inconsistent ways they supported the person. The methods described were not always reflective of best practice. This meant this person's needs were not being well met.

People had a health action plan in place. Although these are in line with good practice recommendations for people who have a learning disability, they had not been effectively used to help people and the staff that support them to ensure healthcare needs were met.

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Throughout our inspection we heard and observed staff offering people some choices about their clothes and food for example and patiently explaining things to enable people to make choices regarding their own care. On other occasions we observed that staff presented people with a drink, or food for example without

any consultation. Where it had been assessed that people did not have the capacity to make some decisions we saw that best interests decisions had been made.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with did not all understand the DoLS that had been authorised for people living at Charles House. One member of staff told us, "Everyone here has a DoLS." Another member of staff told us, "The DoLS is about people's food, and going out." This wasn't correct. The registered manager demonstrated some knowledge of the MCA. When restrictions on people's liberty had been identified as necessary to keep people safe, applications had been made by the registered manager to the supervisory body and systems were in place to ensure these were applied for again, before they expired. We identified that for some people less restrictive ways of providing support could be explored. These included checks on people at night that were being undertaken without any clear purpose or based on any specific assessed risk.

The staff team had been trained, however this training had not been effective at ensuring staff had knowledge about how to provide good quality, safe care that reflected best practice guidelines for people with a learning disability. We asked staff about the training they had received. Staff confirmed they had received the training they needed to meet people's needs, and one member of staff told us, "We get all the training we need. Often we can pick dates that are convenient, or else the manager sorts our rota to ensure we can be released."

The registered manager informed us that there had been no staff recruited recently that required induction or the Care Certificate. The Care Certificate is a nationally approved set of induction standards that ensure staff have the knowledge they need to provide good, safe care. We were assured that an induction would be provided if required. We saw that arrangements had been made to ensure a member of staff that had recently returned to work after an extended break was supported to refresh and update their knowledge and competencies.

Staff confirmed and records showed that regular supervisions were offered. Supervision is an important tool which helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. In addition to this formal support through supervision most staff reported feeling well supported by their peers, the leadership team of the home and the organisation.

We saw people enjoying the food that had been provided. We were informed the main meal of the day was prepared in the home each day, and on the day of our inspection this smelt tasty, and people told us or indicated with gestures that they were looking forward to eating it. We asked staff how people were given choices in regards to their meals. Staff told us they planned the menu taking into account what they knew about people's preferences. They told us that for people who were unable to express verbally what they wanted to eat that picture cards of meals were used, or that people were offered two boxes of cereal, or two packets of crisps for example to choose from. This ensured people were offered food that they enjoyed.

Requires Improvement

Is the service caring?

Our findings

We last inspected Charles House on 30 January 2015. At that inspection we found that people were consistently receiving a caring service, and we rated this area as good. This inspection identified that while individual interactions with staff were still kind and compassionate, people did not consistently receive a caring service.

Some of the people we met were not able to explain their needs and wishes easily. We saw occasions when people were not given the time and opportunity to make a choice. Items of food and drink for example were just placed in front of the person. The way people communicated was understood well within the home, but this information had not been documented or developed into a tool that would help people communicate with their family and other people they might meet, which would be a way of promoting people's independence. One relative we spoke with told us that the staff understood their family member's communication style better than they did. While it was positive this knowledge and understanding had been developed, enabling the person to communicate further with their family would be very positive for all involved.

We observed other occasions when staff worked patiently with people, trying to help people understand questions and make choices. We observed staff using their knowledge of the person, and their experience of what different words and gestures meant to help people make choices and express their wishes. For example, we saw one person using signs and gestures. Another staff described how a person would choose between items shown to them by pushing away the unwanted one.

We some saw examples of the care provided focussing on the task rather than the individual. At lunch time only two people were at home. The meal was served and people were supported to eat in a way that was 'functional.' The opportunity was missed to make the meal time an enjoyable experience. People could have been involved to a greater extent in the preparation of the meal. We saw one person wore a protective apron. This was placed onto the table and the plated meal placed on top of the apron. Staff stood to the side of the person to feed them and there was no communication between the staff member and the person. The person was not offered a drink, and was given the first spoonful of their desert whilst their savoury course was still in their mouth. The entire meal was eaten in a matter of minutes. While this did ensure the person's nutritional needs were met, it did not provide the person with a pleasant or positive mealtime experience. This was not respectful to people.

Two of the six people we met had higher support needs, and found engaging and communicating with other people difficult. The staff we spoke with did not consistently recognise the unique value of these two people, and often spoke about what they could not do, and described how they chose not to partake in the lifestyle and activities chosen by the majority. Care and support that embraced the people's strengths and interests had not always been provided. People were at risk of being both physically and emotionally isolated. Failing to identify and meet these was evidence that the culture of the service was not consistently caring. Although all of the interactions we observed between individual staff and people were well meaning we were concerned that the culture of the home failed to recognise actual and potential harm experienced by

people. The lack of action to safeguard and effectively support people was evidence that this service was not consistently caring.

Failing to provide care that demonstrates dignity and respect is a breach of Regulation 10 (1-2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that they had got to know well. There were many staff who had worked with people for a number of years. People had been supported to maintain relationships with people that were important to them. The relatives we spoke with were very complimentary about staff at the home, and told us they were made welcome by staff when they visited their family member. One relative told us, "It's a home from home. You get such a lovely greeting. I've not got enough good words to say about them." Another relative told us, "It suits [name of person], they are happy there." Staff we spoke with were enthusiastic about the people they were supporting. One member of staff told us, "I love working here. I enjoy seeing a smile on people's faces. The people living here are like family to me."
There were some opportunities for people to take part in everyday living skills, for example shopping for personal, food and household items. We saw that staff sometimes prompted people to carry out tasks needed rather than to do things for them. This helped to maintain people's independence. Staff we spoke with described how they promoted and maintained people's dignity and showed respect. One relative we spoke with told us, "Staff are very respectful to the people living here, and their visitors."

The majority of care and support we observed was offered with kindness and compassion. The interactions between staff and people living at this home showed that people had developed trusting relationships with staff. People looked relaxed and calm with the staff that were supporting them. One relative we spoke with told us, "It's interesting to see how the staff are with the more challenging people, to see the patience they show and how they encourage them." We observed examples of caring practice from staff during our visit. We saw people approach staff for comfort or reassurance when they were unsure or concerned about something. Staff responded by giving the person a hug, or verbally reassuring them.

Staff we spoke with were aware of the individual wishes of each person, relating to how they expressed their culture, faith and gender. Opportunities had been provided for people to attend places of worship. The meals on offer were culturally diverse, and staff told us how people enjoyed a wide range of dishes, both prepared by staff in the home, and when people ordered a takeaway or ate out. We were informed how two people were regularly supported to style their hair in a way that reflected their culture. People could be confident their individual preferences and choices relating to their culture, faith and gender would be respected.

Requires Improvement

Is the service responsive?

Our findings

We last inspected Charles House on 30 January 2015. At that inspection we found that people were receiving a responsive service and we rated the service as good. This inspection identified that this rating had not been maintained.

Our observations and people's care records showed that the service offered did not consistently ensure that each person was provided with care and support that was tailored to meet their individual needs and wishes. For example each of the six people living at the home had an activity plan that detailed exactly the same activity for each person for the entire week. People we spoke with were able to describe some of their individual interests and preferences however we did not see that people had been able to pursue these expressed interests.

We observed that four of the six people were offered regular opportunities to participate in leisure pursuits and activities. During our inspection we saw four people use the homes vehicle to access the community. The purpose or destination of the activity was unknown when the group of people left the home. There was no clear purpose to the activity. It was not evident that people had chosen this or how it would benefit them. While it was apparent people enjoyed these activities, the activity plan had not been individualised to reflect activities people enjoyed. We found that two people with more complex and specific needs had much less access to activities. Activities that these two people were known to enjoy had not been regularly provided. These two people were at risk of social isolation, and the registered provider was unable to show that their specialist and more complex care needs were being well met.

Failing to provide care that is person centred, that meet's people's needs and which reflects their preferences is a breach of Regulation 9 (1)(a-c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection a new care planning system had been developed. This contained some very person centred and individual information about each person, including how the person preferred to be supported, and unique personal information such as the number of pillows the person liked to sleep with.
We did not find that these were an accurate or complete reflection of people's needs as significant areas of people's needs including how to keep people safe and how to support people to live a lifestyle that was consistent with their needs and wishes had not been addressed. There was no evidence that people themselves had been involved in developing or reviewing their care plan. Relatives informed us they were involved in their relatives care and that the home kept them up to date on any changes in care. One relative told us, "I have looked at the care plan with the manager. I'm always involved in meetings and I look at the care notes when I visit. If there's anything I can ask questions."

The registered manager told us that there had been no complaints received in the last twelve months. Relatives we spoke with told us they rarely had concerns but if they did they would be confident to raise any concerns with the registered manager. One relative told us, "I have never had any worries." There had been no structured opportunities provided for people using the service to provide feedback or to make a

complaint.

Inadequate

Is the service well-led?

Our findings

We last inspected Charles House on 30 January 2015. At that inspection we found that people benefitted from a well led service and we rated the service as good. This inspection identified that the quality and governance of the service had not identified where improvements were needed. We have rated this key question as Inadequate, as people were not always safe, their care needs were not always met and overall six legal regulations had not been met.

Our inspection identified that this service had not been consistently been well led. We found that the culture of the home did not always question practice, and that the leadership was not driving forward improvements. The checks [governance] arrangements had not been effective at identifying where the service was not complying with the requirements of the law or current best practice guidance.

There was a registered manager in post. 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. Our discussions with the registered manager indicated they had some knowledge about people's needs.
However they did not demonstrate knowledge about current best practice for people with a learning disability, where to get advice and information, and they showed an over reliance on the support of the multi- disciplinary team. Additional specialist resources were not available from the registered provider. This meant the registered manager had been unable to make progress with needs and risks people experienced, while referrals to the multi-disciplinary team were made.

After our first days inspection we shared feedback about our inspection findings with the registered manager and registered provider. When we returned on 31 August 2017 we found that the situation was unchanged. Action had not been taken in response to our concerns about people's safety or to progress any of the other issues we had raised. This meant that people continued to be touched inappropriately without any safeguarding referrals being made. Issues that we identified in relation to the culture of the home and people's experiences had not been addressed. This did not demonstrate good leadership or effective governance.

The registered provider had developed and completed a regular audit of the home. This had not been effective at ensuring the service being offered was meeting people's needs, was safe and meeting the requirements of the law. These audits had not provided a good overview of the operation of the home, or picked up on staff practice or the quality of life experiences for people living at the home. The registered manager had a number of checks that they regularly undertook to ensure the premises were safe, and they had made a number of improvements to the environment since starting work at the home in June 2016. Throughout our inspection we found that the registered manager was receptive to feedback however they demonstrated a very reactive approach and neither the registered manger nor registered provider shared with us a development plan, or clear vision for the progression of the service.

No accident or incident reports had been completed in 2017. Our inspection identified that incidents had occurred however these had not been reported internally or to other agencies when this was required. Failing to record and act on such incidents means that longer term actions would not be taken to reduce the risk of similar incidents occurring. Records had been made in relations to some people's behaviour. These records had not been analysed or interrogated to establish its significance, and to inform the planning of care, management of risks and the delegation of staff. Doing this is a way of reducing the risk of people experiencing similar incidents again in the future.

The systems in place to ensure that the quality and safety of the service were being assessed, monitored and that any identified risks were mitigated were not effective. This had not ensured that people always received a safe and good quality service. This is a breach of Regulation 17 (2) (a-b) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The registered manager had ensured that notification systems were in place. However during our inspection we identified that regular incidents had occurred that should have been reported to both the local authority and the Care Quality Commission as safeguarding. Records showed these incidents occurred frequently and had taken place over a pro-longed period. They had not been identified and reported as required. Failing to notify the Commission about abuse and allegations of abuse is a breach of Regulation 18 the Care Quality Commission (Registration) Regulations 2009.

Meetings had been held with the whole staff team and the senior staff team responsible for the day to day running of the home. One member of staff told us, "If I make a suggestion I know it will be considered. Sometimes the decision has to go to head office, but I get feedback. The staff meetings are helpful, they keep us informed of changes and anything new coming up." There were no systems in place to enable people using the service to provide feedback or contribute to the development of the service.

The registered provider is required under the regulations to display the most recent inspection rating to ensure transparency and so that people and their relatives are aware. There was a rating poster clearly on display in the service and on the provider's website.

People using the service and their relatives held the registered manager in high regard and we received feedback that the registered manager was well liked and approachable. One relative told us, "The manager has a good personal rapport with all the people." Another relative told us, "There has been a lot of new furniture since the new manager started. The bedroom furniture is lovely." The staff we spoke with gave us mixed feedback, some telling us of the improvements that the registered manager had made to the home, and others sharing concerns. One member of staff told us, "The manager is wonderful; he's there for you, helps with anything." Other staff shared examples of practice that they felt had been inappropriate and not demonstrated good leadership. We shared these concerns with the registered provider.