Voyage 1 Limited

48 Hafod Road

Inspection report

Hereford
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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

48 Hafod Road is located in Hereford, Herefordshire. The service provides accommodation and personal care for up to eight people who have learning disabilities, physical disabilities and autistic spectrum disorders. On the day of our inspection, there were five people living in the home.

The inspection took place on 8 and 17 August 2016 and was unannounced.

There was no registered manager at this service, and there had been no registered manager in post since June 2016. A manager was appointed after the registered manager left, but they had subsequently left before completing the process to become a registered manager. The home was being managed by temporary managers and an acting operations manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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 were not always protected from harm or abuse. Risks associated with people's individual care and support needs had not been managed.

People did not always receive their medicines safely, or as prescribed by their GP.

People were not supported with their eating and drinking needs. Although people received input from a range of specialist health professionals, their guidance and recommendations were not consistently followed.

People's privacy was not always respected and maintained.

People could not always pursue their individual hobbies and interests, or access the community when they wanted to.

There was managerial and staffing instability in the home, which impacted upon the quality of care people received. Staff and the provider did not always communicate about people's needs and how to meet those. Staff felt unable to raise concerns with management and were reluctant to raise concerns with them.

People were involved in decisions about their care, and staff understood people's different communication needs. People's independence was encouraged.

There was a system in place for capturing and responding to complaints and feedback.

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; if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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 were not always protected from harm or abuse. People's freedom was restricted by ongoing staff shortages. People did not always receive their medicines safely, or as prescribed by their GP.

Is the service effective?

Requires Improvement

The service was not always effective.

Professional and medical guidance was not followed. Where people needed specific assistance with eating and drinking, this was not provided. Staff required further training in their roles to enable them to support people effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was not always maintained.

People were supported by staff who understood their individual communication needs. People's independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not always pursue their individual hobbies and interests. Where in-house activities were offered, these did not always reflect people's preferences or meet their needs.

People's changing needs were responded to. There was a system in place to capture and respond to complaints and feedback.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post. Staff were not always certain of their roles, or what was expected of them.

Communication between staff and the provider was not effective, which had an impact on the people living at the home.	

48 Hafod Road

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.

We made an unannounced inspection on 8 and 17 August 2016. The inspection team consisted of one inspector.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.

Before the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We asked the local authority if they had any information to share with us about the care provided by the service. Due to ongoing concerns regarding the care people receive, there is a local authority action plan in place with the provider.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spent time with three people who use the service. We spoke with the acting operations manager, two temporary managers and five members of staff, which included one agency staff member. We also spoke with two relatives, and four health professionals, which included a psychologist, a continence nurse, a speech and language therapist and an occupational therapist. We looked at two care records, which included risk assessments, capacity assessments and guidance from health professionals. We also looked at

the medication administration records and complaints received.

Inadequate

Is the service safe?

Our findings

We looked out how the provider protected people from harm or abuse. Prior to our inspection, the provider and the local authority notified us of an incident in which a person living at 48 Hafod Road suffered harm and abuse. This incident involved two people, one of whom had recently moved into the home. Before the person had moved into the home, a pre-admission assessment and a risk assessment was completed by the provider. The provider identified that without appropriate support, the person could pose to a risk to the safety of other people living at the home. A protocol was in place to provide instruction to the staff about managing the potential risks posed to other people living at the home. This protocol was not followed by staff, which resulted in harm to another person living at the home. Following the incident, the provider did not take the necessary actions to notify the relevant authorities within a timely manner. Specifically, the out of hours safeguarding team were not informed. This had meant a delay in taking the appropriate action to keep people safe.

After the incident had occurred, staff told us they were made aware of a report written by a health professional. This report contained specific information about the person, their support needs, and the risks posed to people and staff living at the home. The report had been received by the provider 10 days' before the incident, but had not been shared with staff. We spoke with the provider, who confirmed the report had been received as described by staff. The report contained additional important information regarding the person's needs and potential risks they posed. This additional information had not been considered by the provider in respect of how they planned to support the person at the home and keep people safe.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at how the individual risks associated with people's care were managed. We saw that individual risk assessments were in place in respect of areas such as personal care, accessing the local community and managing anxiety. Although people's risks had been assessed, we found that these were not always effectively managed or known by the provider. For example, staff and a relative expressed concern about a person living at the home. They told us this person had previously gone missing when out in the community and a result, they needed two members of staff to support them when outside of the home. However, staff told us that recently, the provider had suggested that one member of staff accompany the person. Staff told us this increased the risk of the person running away and going missing again. We spoke with the provider about this concern; they were unaware of the previous incident in which the person went missing. Once the provider familiarised themselves with the previous incident report, they said they would ensure there was suitable staff support for this person when in the community.

Due to the complex health needs of people living at the home, we were unable to ask people whether they felt there were enough staff to meet their needs and keep them safe. Staff and the provider told us that over a two month period, six members of staff had left the service. Staff and relatives told us this had an impact on people's freedom, as people living at the home required staff support to access the local community. Two health professionals we spoke with told us they had concerns about the loss of experienced members of staff and the impact this had on the people living at the home. They told us that it resulted in a high use of

bank and agency staff, which was of concern as people living at the home needed consistency.

We saw that in two people's care plans and risk assessments, it stated that it was important for them to be supported by staff who knew them well. This was in order to reduce their anxiety levels, provide routine and consistency in their care. However, due to significant changes in staffing and a reliance on agency staff, we saw during the course of our inspection that one person received their one to one hours from an agency member of staff. The member of staff told us they had last worked at the home a year ago and therefore, did not know the person as well as existing members of staff. This was not in accordance with the person's risk assessment. We spoke with this person's relative, who told us that the person's anxiety levels and self-injurious behaviours had increased as a result of being supported by unfamiliar staff.

We spoke with the provider about these concerns, and they told us they were trying to block-book a pool of familiar agency staff to ensure there was consistency in people's care. The provider also told us that as a minimum, there had to be two members of existing staff on every shift. During the course of our inspection, we found that there were five members of support staff on duty, two of whom were existing staff members. Staff and the provider told us the minimum amount of staff on duty at any time was three members for five people.

We looked at the checks carried out by the provider before members of staff could work with people. Staff members told us before they were allowed to start work, checks were completed to ensure they were safe to work with people. Staff told us references and checks with the Disclosure and Barring Service (DBS) were completed and once the provider was satisfied with the responses, they could start work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people.

We looked at how people received their medicines. We found that there were occasions over the last two months where people's medicines had not been re-ordered when needed. As a result of this, one person had received half the prescribed dose of their medicine because there was not enough left to give them the correct amount. This medicine was prescribed to ease muscle contractions and pain. We were unable to ask the person how this reduced dose had affected them, but staff we spoke with told us how important it was for the person to receive this medicine as prescribed by the GP and that without the correct dose, the person would be in discomfort. Medical advice had not been sought prior to halving the dose of this person's medicine to ensure it was safe to do so, nor had it been reported as a medication error. We discussed this with the provider, who told us that the medicines policy had not been followed in this instance and that all staff would be reminded of the need to seek medical guidance before making changes to people's prescribed doses.

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

Requires Improvement

Is the service effective?

Our findings

We looked at how people were supported with eating and drinking. During the course of our inspection, we asked the temporary managers if any people received assistance with eating and drinking from the Speech and Language Therapy Team (SaLT). The managers we spoke with were unfamiliar with people's support needs in relation to eating and drinking and we were advised to ask the manager about this. However, we were unable to as they were absent from work during the course of our inspection. We spoke with staff about their understanding of the specialist support people needed, such as soft food diets and choking risks. Staff told us that they supported people by eating their meals with them to ensure support was present. However, no other examples were provided about how SaLT guidance was adhered to.

We spoke with a speech and language therapist, who told us their guidance was not being followed regarding foods one person should and should not be offered. They had observed the person had been given a meal which contained food which was contrary to the specific guidelines provided. This food was not suitable for the person to eat due to an identified choking risk. The member of staff had been unaware of the guidelines; these were not displayed for all staff in the kitchen area. The speech and language therapist told us that they had asked staff to record one person's daily food and fluid intake due to concerns over weight loss, but this had not been followed. As the medical guidance was not followed, this health professional was unable to identify the factors which may have contributed to the person's weight loss. We spoke with the provider about these concerns, and they told us that all staff would be made aware of the guidance and the need for it to be followed. They told us that agency and bank staff would also have access to this information and they would have to read it before supporting people with eating and drinking.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health professionals we spoke with expressed concerns over their recommendations and guidance not always being followed. One health professional told us they had recommended a piece of specialist equipment to assist one person with their personal care needs, but two months had passed without this being implemented. This meant the person did not receive the full support required to meet their needs. We spoke with the provider about the specialist equipment, and they told us they would ensure the recommendation was followed as matter of priority. Another health professional told us there was an inconsistent approach from the staff team in regard to how their guidance was followed. They told us that as there was not a stable staff team at present, there was an inconsistent approach in how staff supported people and guidance from health professionals was not always followed. For example, in relation to managing people's behaviours. They told us they had noticed deterioration in people's wellbeing and behaviours as a result. This concern was shared by staff and by the relatives we spoke with.

One health professional we spoke with told us they believed that staff needed additional training and managerial support in order to be effective in their roles. This was in respect of people's eating and drinking needs. The health professional told us they would arrange some in-house training for staff. The health professional's concerns about staff training was reflected in what staff and temporary managers told us. One

manager told us, "The staff have not been given the training needed to do their jobs properly. Their roles haven't been fully explained to them in the past". The manager told us that in recognition of this, some in-house training had commenced regarding keyworking roles. One member of staff told us, "We were asked about three or four months' ago whether there was any further training we wanted. I selected some training, which I really wanted to do and would help me in my role, but nothing has happened since".

We found that staff had recently undergone bespoke training in relation to a specialist piece of equipment used by one person who was due to move into the home. The provider told us that all staff would need to be trained in using this equipment before the person could move in. The provider had also arranged face-to face- safeguarding refresher training for all staff and management to ensure they knew how to correctly report concerns regarding harm or abuse. Staff told us they had undergone an induction process before starting their roles. The provider explained to us the induction process all new staff had to complete, which included shadowing experienced members of staff for two weeks, reading people's care plans and completing e-learning courses.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

We looked at how the MCA was being implemented. Staff had a good understanding of the Act an told us they had received training on the subject. Where people lacked capacity to make certain decisions, meetings were held with the person, relatives and health professionals to ensure staff acted in that person's best interests.
At the time of our inspection, every person living at 48 Hafod Road had been assessed in respect of their individual care and support needs, and the provider had ensured DoL applications had been submitted accordingly. We reviewed a sample of these authorisations and saw that each authorisation was specific to individuals' requirements. For example, one authorisation related to the need for locked cabinets, and another was in regard to a person's finances. Staff we spoke with knew why DoLS authorisations had been made for people and were able to explain to us the individual restrictions for people. The provider had implemented a tracking system for DoLS applications and authorisations so they could ensure people were not unlawfully being deprived of their liberty.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection, we became aware that members of staff had contacted relatives and shared confidential information with them about people living in the home whom they were not related to. This information was about people's individual care and support. As a result, people's privacy was not always maintained. The provider told us they were aware of this breach of people's confidentiality, and that there would be an investigation into the matter. The provider also told us that all staff would be reminded of the need to respect people's confidentiality and not discuss people's care and support with other people's relatives, or people unconnected to them.

We found that a keyworker system was used to ensure people were involved in decisions about their care and support. A keyworker is a member of staff who takes a lead role in working with a person to understand their preferences, changes in health, social and emotional needs, and in communicating with relatives and health professionals. We saw that monthly meetings took place with keyworkers and the people they supported, which covered areas such a holiday suggestions and menu choices. Keyworkers we spoke with were knowledgeable about the people they supporedt, both in terms of their support needs and their likes, dislikes and personal preferences. One keyworker told us, "I see my role as standing up for [person's name] as they can't stand up for themselves". The keyworker and the provider told us that they had recently arranged a sensory light for one person in their bedroom, which had benefited the person. We saw that in addition to staff advocating on people's behalf where necessary, people also had access to independent advocates; one person had an independent advocate in place at the time of our inspection.

We saw that people and their relatives were involved in the implementation and reviews of their care plans. We saw that people's care plans contained 'relationship maps', which set out the important people in their lives, as well as information about what was important to them. For example, it was important for one person to have music on when travelling in a car. Staff we spoke with were knowledgeable about people's care plans and how people wanted to be supported.

We found that people's individual communication needs were known by staff. For example, one person had pictorial flash cards to enable them to communicate. Staff also understood people's body language and non-verbal cues. Staff told us that if one person tugged a staff member's arm when out in the community, this meant they felt uncomfortable and it was too noisy for them. Staff explained other communication preferences to us, such as using short sentences and offering visual choices. This information was reflected in the person's care plan. Staff told us how important it was for people's care plans to be up to date and referred to as there were so many bank and agency staff working at the home at present. We spoke with an agency staff member, who told us they were given time before the start of every shift to read the care plans and ask any questions about the care and support people needed.

We asked staff how they upheld people's dignity. They explained to us that they respected people's preferences in terms of whether they wanted male or female support with personal care. They also explained how they maintained people's dignity in respect of continence needs when out in the community. We saw that people received their medicines either in their bedrooms or in the staff office, rather than in

front of other people living in the home. Staff told us this was so that people received their medicines in a way which maintained their dignity.

We saw that people's independence was encouraged as much as possible. People were encouraged and supported to carry out house-hold chores and aspects of their own personal care, if able to do so.

Requires Improvement

Is the service responsive?

Our findings

Staff, relatives and health professionals told us that people did not always receive care and support which reflected their individual preferences or met their needs. For example, people were not always able to pursue their individual hobbies, interests and social and leisure opportunities. Staff told us people's activities had been affected over the course of the last three months as a result of staff shortages. One member of staff told us, "[person's name] deserves a better way of life then they are currently getting. They love going out for meals and going out for walks, but it doesn't happen as much as it should and it makes them really frustrated". They told us that sometimes, this person did not go out for two weeks, and that this had been ongoing for a period of five months. They showed us this person's activity diary which reflected this. Health professionals we spoke with told us they were concerned about the lack of social opportunities for people, and the effect that had on their wellbeing. A health professional told us they had observed a deterioration in one person's wellbeing as a result of not being able to go out as much as they wanted to. They told us that although the person was meant to get a set amount of one to one staff support a week to go out into the community, this did not always happen.

Staff we spoke with told us the provider had recently reviewed people's activity plans with the aim of making improvements to these. Staff told us that this review had been done by a manager from another service who was unfamiliar with the needs of the people living at the home. They told us the activities put in place were not always suitable. One member of staff told us, "They arranged an in-house quiz for someone who is non-verbal. They just did not understand the needs of the people living here".

We spoke with the provider about the effect of staff shortages on people's hobbies and interests. They told us that whilst people's activities were important, staff shortages meant the focus had to be on having enough staff on duty to keep people safe. This meant that at times, there were not enough staff available to support people with their individual interests. The provider told us in-house activities had increased so that people could still take part in things they enjoyed but that when staffing levels had increased, people's individual activities would resume. On the day of our inspection, we saw one person was supported with their individual interests in the home. However, a relative told us they were concerned that some of the in-house activities offered were not always appropriate and did not reflect people's preferences. These activities included household chores, such as cleaning. We saw that this was displayed as an activity on the activity board in the home. We spoke with the provider about this, who told us that more creative approaches would be applied to thinking of in-house activities for people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider responded to changes in people's health and wellbeing needs. We saw that reviews of people's care took place, which were attended by people, staff, relatives and health professionals. The purpose of the reviews were to look at whether there were any changes in people's needs, and decide how best to respond to and meet these needs. We found that staff were vigilant to changes in people's health and behaviours and were quick to notify management and health professionals of these changes. We

saw that recently, a psychology referral had been made for one person in respect of concerns around their wellbeing.

We looked at how the provider responded to complaints and feedback from people, relatives and health professionals. We found that there was a complaints system in place, and the information about how to complain was clearly displayed. A complaints book was also left in the reception area for relatives and visitors to complete. We saw that this book was reviewed regularly and that all comments and complaints had been responded to. For example, a relative had complained about not being informed of there being a new manager in post. The manager had looked into this, and established that they did not have up to date contact details for the relative, which was subsequently rectified. In the event someone was unsatisfied with the response they received to their complaint, we saw this was then reviewed by an independent operations manager who had no association with the service. As part of the keyworker role, they met with people on a monthly basis and reviewed whether they, or their relatives, had any concerns, complaints or suggestions. These were then logged and acted upon.

Inadequate

Is the service well-led?

Our findings

We looked at how the provider maintained oversight of the quality of care provided to people living at Hafod Road. We found that due to the managerial instability, the provider had not identified all of the concerns identified by us during the course of our inspection. For example, the provider had been unaware of a recent medication error, and that specific guidance and recommendations by health professionals was not being followed. As medication audits had not been carried out for a period of two months, the issue regarding the person not receiving their prescribed medicines had not been identified prior to our inspection. This meant that no action had been taken in this time period regarding ensuring the safe administration of medicines. The provider acknowledged that due to changes in management, quality assurance checks had not been regularly carried out and that as result, not all issues affecting the quality of care people received had been identified and acted upon.

There was no registered manager in post. The previous registered manager had been in post from April 2015 and left in June 2016. The deputy manager had been in post for three months and was appointed the manager of the service. The manager was in post for a period of four weeks before leaving the role and had not completed the process to become a registered manager. By not having a registered manager in post, the provider was in breach of the conditions of their CQC registration .

The provider was ensuring managerial cover and support by using managers from other services on a temporary basis. An acting operations manager had managerial oversight of the day-to-day running of the home. Staff, relatives and health professionals we spoke with expressed concern over the managerial instability in the home and the amount of staff who had recently left. One health professional told us, "There is this ongoing cycle of managerial changes and it is now at crisis point". They told us that as there were several managers providing cover, staff sometimes received conflicting advice and guidance. They told us this was of particular concern as the people living at the home needed stability, consistency and routine.

We spoke with staff, who told us the requirements of their day-to-day role changed frequently. One member of staff told us, "It changes every week. This week, we have been told that one member of staff is to give people their medication and another member of staff is to check. The other week, it was two members of staff. It can be confusing and we don't really get any explanations". Another member of staff told us, "They are making too many changes all at once. Some days, there are about ten different memos to read". The provider told us that staff meetings had recently become mandatory for all staff so that any changes to their role could be discussed as a team. As this was a new initiative, staff could not tell us whether mandatory staff meetings were of benefit.

Staff told us that morale was low in the team as they did not feel listened to, or supported and appreciated by the provider. One member of staff told us, "There is no real appreciation from managers about all the extra hours we are working". Staff were of the view that the recent safeguarding incident had not been managed in an open and transparent way. They told us they had expressed concerns to the former registered manager and provider about the potential for the incident to occur, but that no action was taken. The person who moved into the home had different needs to the other people living in the home. Staff told

us they were not trained in how to support the person and had no prior experience of supporting people with those particular needs and as a result, they did not feel equipped support the person and keep the other people living in the home safe. Staff told us they felt unsupported after the incident. One member of staff told us, "There was no de-brief. There was no recognition that maybe we should have been listened to, or that maybe we had been right". Another member of staff told us, "We were blamed for it all. We are nervous about doing anything now as we feel if something goes wrong, we will get the blame again. Some staff are reluctant to take people out in case something happens and they get told it was their fault".

We spoke with the provider about whether any changes would be made to their pre-admission assessment process, and sharing information with staff. They told us about the pre-admission assessment process, "It is important that we are asking the right questions". They told us that this was currently under review and that the plan was to involve staff in this review process and ask for their feedback. However, staff had not yet been informed of this.

The provider had recently arranged off-site support sessions for staff. These were facilitated by the acting operations manager and a member of the provider's human resources team. The purpose of these sessions were for staff to express any views, concerns, or make any suggestions. However, attendance at these sessions was low, with only two members of staff attending. Staff we spoke with recognised the provider wanted to offer support, but that they felt the sessions should have been arranged earlier. One member of staff told us, "What is the point of having these sessions now, when so many of the staff team have already resigned and left? It is too far down the line." Another member of staff told us, "I didn't attend. They never listen to us and we always get the blame. They never look at themselves and take any responsibility, it is always put onto us."

We found that the communication between the provider, management and staff was not always conducive to working as team and supporting the people living at the home. We saw recent examples of how this situation had impacted upon the people living at the home. Recently, the washing machine at the home had stopped working. There was one instance where a person living at the home did not have enough clean bedding. This was reported to the local authority by a staff member, rather than raised with management and resolved internally by means of ensuring the person had sufficient clean bedding that day. Staff told us they had recently completed four incident report forms regarding one person's behaviours and their concerns about these. They told us that no action had been taken by the provider. We asked the provider about these reports, who told us they were unaware of any concerns raised. These reports were later found in the office. This meant there was a delay in addressing the concerns raised in the reports.

We spoke with staff about the provider's whistleblowing procedure and what they would do if they needed to raise an alert about practice at the home. The term whistleblowing can be defined as raising a concern about a wrong doing within an organisation. Although staff were aware of the policy and what action to take in the event of wishing to raise concerns, they told us they did not feel confident that action would be taken by the provider. One member of staff told us, "They (the provider) would protect themselves and put the blame onto us." Staff told us they would report any concerns to the local authority and to the Care Quality Commission.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that as a result of the current recruitment drive, a deputy manager and a senior support worker had now been appointed. They told us that once they had finished recruiting and had new support workers in post, they would arrange a team-building day for all staff. They told us they wanted staff to feel

positive in their roles and about the running of the home. We saw that a "feedback day" had been arranged at the home, which was open to relatives and health professionals. The provider told us they had encouraged staff to be involved in this and that it would take the form of a garden fete. The provider told us that feedback received would be used as part of quality assurance measures in order to make improvements to the running of the home. The provider told us that an operation manager from another service would be carrying out quality assurance audits at the home and there would be an action plan put in place, which would be shared and discussed with the staff team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always able to pursue or enjoy their individual hobbies and interests, or take part in social and leisure opportunities. Where in-house activities were provided, these did not always meet people's needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines safely and as prescribed by their GP. Medical attention had not been sought before altering the dose of prescribed medicine.

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 were not protected from harm or abuse. Adequate measures had not been taken to manage identified risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of managerial stability in the home, and no registered manager. This

impacted negatively upon the care people received.

The provider did not have an effective system in place to identify risks to people and monitor the quality of care people received.