Yarningdale Health Care Limited

Yarningdale Health Care

Inspection report

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Ratings

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

Overall summary

This inspection took place on 11, 14 & 18, December 2015 and was unannounced. At the last inspection of the service in April 2014, we found the service was meeting the regulations.

Yarningdale Health Care provides care and support for up to 20 younger adults with complex mental health needs. At the time of this inspection 18 people were living at the service.

The service had a registered manager in post. The home is required to have a registered manager. 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.

Staff were not fully trained to meet the needs of people. They did not have the training the provider considered necessary to support people living at Yarningdale. The provider was aware of this and had not acted on this knowledge. However, they knowingly admitted people with complex needs that staff were not trained to meet.

Staff had received safeguarding training however; they had not used their training appropriately to keep people

Summary of findings

safe. Senior staff did not act on safeguarding concerns that had been reported to them and escalate the information to the LA safeguarding team or to their own internal senior managers. This put people that used the service at risk of abuse.

There were not enough staff to meet people's needs, neither were they effectively deployed to meet people's needs. However, we saw that there were thorough recruitment processes in place.

We observed that some staff were kind, compassionate and caring. However, staff were not effectively supported within their roles.

Staff had not read people's care plans and therefore they were unaware of information relating to people's needs and wishes. They were unaware of how to care for a people in a manner that built on their wish to be more independent and recover from their injury or condition.

Peoples' dignity and independence was not always promoted. People were not offered the opportunity to pursue hobbies and interests both inside and outside the home. They did not have free access to fresh air and some people had not been out of the building, even to the garden, since the summer.

People's feedback about the service had not always been listened to and acted upon. Verbal complaints had not been recorded or investigated in any way.

There was not an effective quality assurance system in place. The quality system failed to recognise the service was not providing personalised care to people to promote their independence, health and welfare.

The service had not always notified the Care Quality Commission of incidents and accidents that occurred in the service.

The staff understood and complied with the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards. However, none of the staff we spoke with understood the implications for people who were living under different sections of the Mental Health Act 1983.

People were given the opportunity to plan their meals and had a choice of nutritious food and drink throughout the day. People were happy with the food.

People's medicines were administered safely and people were supported to access other healthcare professionals to maintain their physical health and well-being.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

Risks to people's health and wellbeing were identified in risk assessments however staff were not aware of them and therefore did not always know how to keep people safe.

There was not enough staff available, neither were they deployed effectively to deliver people's planned care or to keep people safe.

People were not protected from the risks of harm because staff did not recognise when people's safety was compromised and incidents of possible abuse were not reported appropriately. We found that medicines were administered in a consistent and safe manner.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff did not feel supported. Staff did not have the training the provider considered necessary to assist people to live well. People were not assisted to recover from their injuries. There were no therapeutic practices in place to enable people to recover.

People had access to healthcare professionals.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed. However staff were not always aware of how the Act related to other people in the service.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's independence and dignity was not always supported.

People told us they were treated with care and given choices. However, we saw improvements were needed to ensure staff were able to interact with people in a way met that their needs and made them feel cared for.

Is the service responsive?

Requires improvement

The service was not responsive.

People were not always supported to have a good quality of life. They were without stimulation and contact with the local community. Some people had little or no access to fresh air.

Summary of findings

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives. However, the service had failed to act on people's verbal complaints. These were not recorded or investigated in any way.

People needs were assessed and care plans were put in place to meet their needs. The information in care plans was difficult to access and to understand. Staff had not read people's care plans and were unaware of significant facts about people's lives. Staff were not allocated time to read care plans.

Is the service well-led?

Requires improvement 

The service was not well led.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant poor care was not identified and rectified by the registered manager and provider.

The provider had not always notified CQC of any incidents that had happened at the service as required.

The provider did not follow their Statement of Purpose in relation to the training they considered necessary to allow people to have a good quality of life.

Yarningdale Health Care

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11, 14 & 18 December 2015 was unannounced.The inspection team consisted of two inspectors and a mental health specialist advisor.

Prior to the inspection we had received concerning information from local authority commissioners about the service. During the planning of our inspection we reviewed information we held about the provider and the service. This included notifications of serious injuries and safeguarding concerns that we had received. We also had concerns about the way safeguarding and serious injuries were being managed at the service.

We spoke with eight people, five relatives, five care staff, the area manager and the registered manager. We observed care and support in communal areas and also looked around the home.

We viewed six records about people's care and records that showed how the home was managed this included care plans, risk assessments, staff rotas, staff recruitment records and training records. We also viewed six people's medicines records.

Requires improvement

Is the service safe?

Our findings

People were at risk of harm because although people had updated risk assessments in place. These risk assessments did not always identify the risk staff had to manage. For example risk assessments did not always have sufficient detail to assist staff to care for people safely. This included staff delivering personal care to people who had an injury. Staff said there was not enough guidance and information to give them confidence to manage the person's wound care safely. Most staff told us that had not read the risk assessment. We saw one person move in a manner that could have caused them harm and staff did not attempt to assist them until we asked them to. We saw one staff assist another person to move. Their risk assessment showed they needed two staff to enable them to move safely. We pointed this out to the staff who did not recognise that this could have caused harm to the person and carried on regardless until we asked them to stop as the person was at risk of injury. This lack of understanding of the risk involved put the person and the staff member at risk of injury. The provider had not responded to preventing risk in a timely manner. For example where an incident occurred that caused harm the provider had not put adequate training and resources in place to reduce the risk of this happening again. This meant risk was not managed in a manner that promoted safety.

The above evidence showed people were not protected from the risk of harm. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always safeguarded because although staff had received training in safeguarding people they did not always put their training into practice. Some staff reported incidents that concerned them to senior staff. Senior staff did not act on this and escalate the information to the LA safeguarding team or to their own internal senior managers. We were not able to ascertain why staff did not follow through on this. By not doing this the person continued to be at risk.

Staff who reported the incident also failed in their duty of care to ensure people were protected and kept safe and free from abuse. This resulted in at least one person receiving poor care that was verbally and emotionally abusive over a sustained period of several months. The new registered manager had started to address this issue. However, their investigation had not been completed and we are not able to judge if their actions were effective.

The above evidence showed people were not protected from the risk of abuse. This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and people told us that there were not enough staff on duty to meet their needs. The registered manager told us staffing levels were determined by the funding arrangements people had in place. However this did not always work as care of people was task led; People who had a high level of physical needs received more care than those who had mental health or rehabilitation needs. This meant the staffing numbers to care for people who had mental health needs was not considered beyond their physical needs. People told us that this left them feeling isolated and lonely.

Staff said when there was a full complement of staff working there was usually sufficient to care for people. Staff said there was usually some staff member off sick or not at work. A review of staffing rotas showed, from 5 October to 1 November 2015 none of the shifts were fully staffed. The registered manager said that some of the shifts were covered by agency staff. However, the records to show this were not available. Two staff members told us the consequence of this was that in order to keep people safe, they had to stay in bed longer than they would have normally chosen. People told us that during this time they did not have much interaction with staff. While this kept them safe from potential harm, it detracted from the quality of their life as they were unable to choose the times they wanted to get up or go to bed.

People we spoke with said, "Sometimes it's really hard if I am having a bad day and there is no staff about to talk to." Another said, "The girls are nice and will talk to me when they have time."

Staff said the service had a high turnover of staff. They said that this put extra pressure on them.

One staff member told us, "Two staff nurses are leaving and another has just left. We try not to allow it to impact on the care." The registered manager agreed with this and was in the process of recruiting staff. This meant that the service had to use agency staff. The impact of this was people were

Requires improvement

Is the service safe?

being cared for by staff who did not know them well. Consequently regular staff had to spend time supporting agency staff. For example, one agency nurse told us they had not read any care plans and were reliant on care staff for direction. This meant care staff had additional work in supporting the nursing staff and this took them away from their duties.

Staff were not managed and deployed in a manner that ensured people needs were met. Staff moved between floors without due consideration been paid to people's needs. On day one of our inspection we were given the staff deployment rosters. They did not match what we found. The registered manager was unable to explain this but undertook to ensure staff were deployed in a manner to ensure the safety of people. On our return we found that this had not been addressed. Again we found the rosters did not match what the registered manager had considered necessary to keep people safe. For example a staff member changed floors to wrap Christmas presents without assessing the impact on people's safety and welfare. Staff and the registered manager were unable to assure us that peoples' needs were met. This meant that the registered manager and staff did not ensure the needs of people were responded to. Therefore while the numbers on paper were sufficient to keep people safe, staff were not deployed effectively to ensure people's safety.

The above evidence shows that people were not supported by sufficient numbers of staff to meet their requirements. This was a breach of 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had emergency plans in place should there be an unexpected event. There was a file in place that had all the emergency information needed to identify those most at risk and how to best get them to safety. This meant that in the event of an emergency, such as a fire, staff had clear directions on what to do to ensure people's safety. Staff we spoke with were aware they existed.

Risk assessments had been carried out on all aspects of the safety of the building. Where a problem was identified it was rectified straight away. For example during the inspection we found doors shut in a very noisy manner that could detract from the mental and emotional welfare of people close by. When we pointed this out, it was rectified straight away. This meant that people lived in a safe environment.

People had their medicines administered safely and as prescribed. Staff who administered medicines were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records were colour coded to denote different times of the day when medicine administration was required. The medicine for three people using the service was checked and we found the records had been completed appropriately and had no unexplained gaps. Medicine was safely stored in locked facilities and the temperature of designated fridges where medicine was stored was regularly checked and recorded. Any medicine no longer required was appropriately disposed. This approach to administering medicines ensured people had their medicines as prescribed.

People were protected by the provider having thorough procedures in place to recruit staff. Discussions with staff and a review of four records showed staff identity and security checks had been carried out before they stared working in the home. This included checks of their previous work and employment history. Disclosure and Barring Service (DBS) certificates had been obtained for all staff prior to starting to work in the home. Staff confirmed that they did not take up their employment at the home until the appropriate checks such as, proof of identity, references and satisfactory. This helped to ensure only staff who were safe to work with vulnerable people were appointed.

Requires improvement

Is the service effective?

Our findings

People we spoke with said staff were "All right." One person said they were frustrated that staff, "Didn't get them." Staff were not skilled in delivering effective personal care because they did not have the training the provider considered necessary to do this. The provider had identified training they considered necessary to meet the complex needs of people. This included training on how to care for people who were at risk of choking (dysphasia). None of the staff had completed this. This included one staff member who was named in the SOP as having completed dysphasia training. The staff member confirmed to us they had not received this training. At the time of the inspection we saw none of the specialist training had been carried out. During our inspection the registered manager arranged some training to take place in the new year. We are therefore not able to comment on the effectiveness of the provider's training and its impact on the care and welfare of people.

There was no effective systems in place to review or assess the competency of staff once they had completed training. The registered manager said that the nurses assessed the care staff. Nursing staff we spoke with said this was 'hit and miss'. There was a high use of agency staff who were unaware of the needs of people. Therefore they were not in a position to judge if staff were caring for them effectively. This meant that there was no effective system in place to identify and validate training delivered to staff.

The impact of the lack of training was staff were unaware of how to care for people who had different or complex conditions. Among the conditions people were living with were Huntington's disease, acquired brain injury, learning difficulties, depression and other mental health issues. Staff were unable to tell us how people's condition affected them and how to tailor care to ensure they had effective care. We spoke to staff about rehabilitation and therapeutic intervention. One said, "We don't do that here. They just live here." Another said, "I never thought of that, I presumed they were here for live." A third said, "We provide long term care that's it. We don't do rehabilitation but it would be nice to." The provider stated each member of staff participates in continuous training and development to ensure that the most appropriate and up to date practice is adopted. The registered manager was unable to show us evidence of this. This means that the provider was aware of the training needs of staff and had not address the issue leaving people at risk of poor or inappropriate care.

The above evidence shows that people were not supported by staff who had not received effective training to carry out their role. This was a breach of 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a supervision and appraisal system in place. This was not always followed nor was it effective. Staff told us they did not always have regular supervision. None of the staff we spoke with had received an appraisal. A review of the supervision schedule supported this. However, we noted regular supervision had been planned for the coming year. This meant, when supervision was not carried out staff had no effective way of passing on knowledge of people's needs and discuss training needs and wishes. Staff said recent meetings were all about what they have to do. No one listens to them.

Most staff said they did not feel supported. One staff said, "A thank you would go a long way." Another said, "The good nurses always say thanks. It is so nice to hear it and no we don't hear it very often." Another said "The new manager said thanks recently." A staff member said, "I'm leaving as it's too hard here. We do not get the support or training we need to support people. So I'm off."

Staff had received mandatory training in The Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS are legal protections which require independent assessment and authorisation when a person lacks mental capacity and understanding and need to have their freedom restricted to keep them safe. The registered manager was familiar with the process and understood the conditions which may require them to make an application to deprive a person of their liberty to protect them from potential harm. The staff we spoke with understood the principles of the Act and told us how they incorporated it in the day to day care of people.

The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Mental capacity was part of the assessment process to help identify if needs could be met. The registered manager had applied for DoLS appropriately. At the time of the inspection a number of people were subjected to an authorisation under DoLS.

Requires improvement

Is the service effective?

Best interests meetings were arranged as required and in accordance with the MCA. Best interest meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The meetings included the person's representative and other health and social care staff.

Some people were living in the service under different sections of the Mental Health Act 1983. Staff did not know this nor did they understand the implications for the people concerned. This meant that staff did not always know people's rights or their responsibilities to people under the Act. For example one person was subject to a Community Treatment Order section 17A of the Mental Health Act 1983. The person told us they were unaware of this nor did they know or understand their right to appeal to the relevant Tribunal. This meant that they did not have their rights explained or promoted.

One visitor told us "Yarningdale had changed their life because they no longer have to worry about their relative's care. They said "They cared for [person's name] really well they understand [relative's] moods and respond well to them."

People were happy with the food and one person said, "The food is right good, we can eat when we like. My favourite is cereal." Another said, "The cook is really nice and will make us food we like." A third person said, "Someone always check after lunch to see if we enjoyed our lunch."

Menus were decided between people and the cook. Regular meetings took place between them and all people we spoke with said the food was good. We saw there was a varied menu on offer for lunch. People were given time to choose their meal and if needed there was a pictorial menu available to help support their choice of meal.

People were assisted to eat in a calm and dignified manner. Staff we observed were sensitive, patient and kind when assisting people allowing people to set the pace they ate at. Where there was an identified risk of a person choking a nurse supervised lunch in order to be readily available to respond to an incident. However we noted that staff received very basic training on how to attend to a person who may be choking. This was covered on the service's first aid course. None of the staff on duty had dysphasia training. This put the two people who had swallowing difficulties at risk of choking.

People were not assisted to recover from their injuries. For example where people had experienced an acquired brain injury there was no recovery plan in place and no therapeutic intervention.

People using the service and relatives told us they accessed health services and we saw some people had been referred to health professionals when required. This included opticians, chiropodist and dentists. The provider had an arrangement with the local G.P, who attended the home on a regular basis to provide advice and health and wellbeing support where required. Where appropriate people had regular appointment with their health care consultant.

Requires improvement

Is the service caring?

Our findings

One person told us they wanted to work towards living more independently. They said "I want to get my own place and life as I want." Staff and the registered manager were unable to provide us with examples of how they promoted people's independence. We also looked at care plans and found there were no plans in place to assist people to become more independent. Staff and the registered manager were unable to tell us how they promoted people's independence. This meant the service was not always caring, because people did not have their independence promoted.

Peoples' dignity was not always promoted. We saw people move in a manner that did not promote their dignity; this included crawling on the floor. We asked staff about this and were told, "That's [person's name] for you. [Person's name] doesn't like waiting for us". This meant that staff were unaware of the importance of supporting person to move in a dignified manner.

One area of the home smelled strongly of urine and staff were aware of the causes of the strong smell. Staff had given consideration to solving this problem but had not given due consideration to how the smell affected the other people living in that part of the service. Nor was the issue being considered urgent. This meant that people had to live in undignified conditions with this constant strong smell of urine. This detracted from their right to live in a dignified and comfortable manner.

Where people did not have an immediate family or representative we saw the service referred people to an advocate to ensure their point of view was represented. At the time of the inspection no one was using an advocate, however we saw the registered manager had details available on how to access the service.

Some staff were observed to be kind, compassionate and caring. We saw good interaction between people and staff. One person said "It's really nice when the girls have a bit of spare time to chat. They really listen and I feel better after talking to them." We saw staff respected confidentiality and had discreet conversations with people privately without other people listening to their conversations. We saw some good practice in promoting people's dignity. For example, care was delivered behind closed doors and staff were seen to knock and wait until they were invited in to people's rooms.

People and relatives we spoke with told us friends and relatives could visit at any time. We saw a steady stream of visitors throughout the day. One relative told us, "There is no restriction on visiting." Another said, "We can come any time during the day or evening." A third relative said "The staff are wonderful, they show they care about [relative] really well. This impacts on me and helps me relax." This meant the provider understood the importance of family relations to people.

Requires improvement

Is the service responsive?

Our findings

People told us they were not assisted to live full lives. One person told us they did no activities and they had no-one to talk to. They said "Life was lonely and boring." They described their day as "Breakfast, TV, dinner, TV, tea, bed." Another person told us there was nothing to do bar watch TV all day. A third person said "I never get to go out even to the garden except in summer." A fourth person told us they are always short staffed and was waiting for staff to take them to the shop for cigarettes and replacement razor blades. This person had to wait all day until 5.30 pm to be taken to the local shop to buy cigarettes and razor blades. This meant they were without a cigarette all day. A review of activity records supported this.

Staff were unable to tell us how often people were offered the opportunity to leave the home. We saw some people were supported to leave the home on a regular basis. People said they did not understand why they were not offered the same opportunities. The service had activity staff however they were frequently drawn into the basic day to day care of people rather than enhancing the quality of life of people who used the service.

The opportunity to pursue interests and hobbies was not offered to all people. Some people had good access to community life, whereas others had little. For example, the people who had highest needs and no family to speak for them had the least opportunities. Staff were aware of this but were without guidance and direction on how to change it. Overall, staff were unaware of people's social needs and the opportunities they had been given to pursue interests and hobbies.

For example they told us [person's name] had access to the local community. When we checked they had not been offered the opportunity to leave the service for over three months. One person when asked if they felt safe said "What's not to be safe, we never do anything." This meant that people were not offered the opportunity to follow their interests and hobbies. Therefore people were bored and also at risk of becoming socially isolated.

We found, while care plans provided detailed information about each person and across a range of their care needs. The care plans were overly large and were difficult to handle and to follow. They contained good directions to staff on how to care for people. However most of the staff had not read them and were unaware of the useful information they contained. We found it difficult and time consuming to find specific information in them. For example, we found evidence of input from a speech and language therapist with regards to communication and advice on eating. This was important information and there was a risk that staff would not have been aware of it and therefore unable to follow it. Another example was no one we spoke with knew the family history of one person that may have been relevant to how their behaviour was better understood. This was very clearly stated at the beginning of the care plan. This meant staff had missed information they could have acted on to improve the quality of the person's life.

There was no effective way of staff getting the knowledge they needed to ensure they delivered person centred care. We found most staff had not read care plans and relied on handover meetings for details about how to care for people. One staff member said, "We don't have time to read care plans". Another staff member said, "I looked at a couple but we get our information on handovers so there is no need to look at them." Handover notes were not available and this was done verbally with some staff taking their own notes. This meant there was a risk information passed on was not consistent. This put people at risk of poor or inappropriate care.

The care plans did not include therapeutic or recovery plans to enable people to either recover or to live better with their condition. The provider recognised the importance of promoting independence, establishing and maintaining links with the community within their aims of the service. They also recognised the importance of accessing further education and lifelong learning. Staff were unaware of the provider's philosophy and this meant none of it was put in place to ensure people were facilitated to recover or to improve the quality of their lives. This meant the provider was not providing the care they said they would.

The above evidence shows that people did not received care that was appropriate to their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints process in place. Most people we spoke with knew how to make a complaint. There were no complaints outstanding at the time of the inspection. However some people told us they frequently

Requires improvement

Is the service responsive?

complained to staff about being bored and they felt they hadn't been listened to as nothing had been done to address their boredom. We saw that there was no record of these verbal complaints. Therefore they could not be investigated as the provider did not have an effective means of collecting and responding to more informal complaints, such as these verbal complaints. Residents meeting had not been planned for the coming year. Therefore people did not have access to more informal ways of expressing their dissatisfaction. This meant people who do not have the ability to write may be excluded from the complaints process.

There was no recognised tool or method used to determine staffing levels. The registered manager told us staffing levels were determined by the funding arrangements people had in place. The manager said that this did not always work because contrary to their funding people who had a high level of physical needs received more care than those who had mental health or rehabilitation needs. The staffing numbers to care for people who had mental health needs was not considered beyond their physical needs. People told us they were feeling isolated and lonely.

Requires improvement

Is the service well-led?

Our findings

We found the management team working at the service was not fully aware of the issues in the service. During our inspection we identified significant shortfalls in all aspects of the running of the home. This included failures in safeguarding practices, deployment of staff, training and supervising staff, planning and delivery of people's care and following their own SOP in how to care for people. As a result, the service was not delivering care to people that reflected their changing needs, had not offered therapeutic services and had not planned and assisted people to recover. We discussed our concerns regarding care to the regional and registered manager and neither was aware of the need to assist people to recover. This meant that people who used the service were not offered the opportunity to have their needs and aspirations met and were offered basic task based care.

Quality checks completed by the management team were not always effective in improving the quality of care administered to people. For example the management team was aware the staff were not adequately trained to deliver care in the manner set out in the SOP. We were told that the training was planned however we noted on the first day of our inspection visit none of this training had been planned. This meant that the provider was aware the staff were not trained to deliver person centered care to people and that the care delivered was task based.

Staff who supervised other staff were unaware of or negligent in their duty of care to record and report incidents of safeguarding raised in supervision. The registered manager told us supervision records covering a significant safeguarding incident involving people using the service were either missing or not completed. Because of this the registered manager had no way of monitoring incidents that needed to be responded to urgently. This left people open to continued abuse. . Records that were available for other serious incidents did not sufficiently identify and mitigate risk. We saw care plans and risk assessments of people similarly at risk had not been updated to reflect any learning. This was important given the nature of these incidents and the complex needs of people using the service.

The registered manager told us they were aware the service was not meeting the very broad spectrum of people's needs and was working towards meeting these. However they continued to admit people to the service with very complex needs where staff did not have the skills and training to meet the person's needs. This meant the registered manager was aware people were at potential risk of poor care.

There was a lack of effective management and management structures in the service. This resulted in staff not been effectively managed. For example activity staff took direction from those who were most vocal and 'able'. This included people's relatives. They told us they cancelled an outing with several people because they didn't have support or confidence to refuse what they considered an inappropriate request. This resulted in what we were told was unfair distribution of their time leaving some people without stimulation and occupation. Their role was not understood or respected. They struggled, without management and guidance to provide meaningful activities and assist people to follow their interests. Staff chose where to work rather than where they had been deployed to. This meant most people in the home did not have occupation and were bored on an ongoing basis.

Staff were not managed in the best interests of the people. For example a high number of staff had not read care plans and were unable to tell us about the people they cared for beyond their basic care needs. The registered manager did not ensure staff had protected time to read care plans and agency nursing staff relied on care staff for direction. This meant staff were not sufficiently aware of people's needs and wishes.

Staff lacked motivation. There was high turnover of staff and one staff member we spoke with said they "Couldn't wait to leave because the stress is too much." We discussed the high staff turnover with the registered manager who said they were aware of it and were trying to address it through recruitment. We were told that staff were stressed because the service had to rely on agency staff. The registered manager told us once they had recruited the staff they needed and had a new management structure in place morale would improve.

The provider did not always have systems in place to review accidents and incidents. Prior to the registered manger commencing their post in July 2015 incidents were not reported appropriately to the Local Authority or to the Care Quality Commission (CQC). By not having this information available, CQC were unable to determine the

Requires improvement

Is the service well-led?

safety of the people who lived at Yarningdale. Between January and June 2015 there were 21 unreported incidents and accidents. This meant there was a potential increase of risks to the safety and welfare of people.

The above evidence shows effective systems were not in place to assess, monitor and manage risks to people's health and wellbeing. This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People who use service were not protected against the risks of poor care because the provider did not offer personalised care. People were not assisted to have a full live. There were no processes in place to aid recovery. Regulation 9 (1) (3) (a) (b) & (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use service were not protected against the risks of unsafe care and treatment because the provider did not respond in a timely and appropriate manner to reduce identified risk. Regulation 12 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who use service were not protected against the risks of abuse because staff did not understand their duty of care to keep people safe. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have effective systems in place to review and

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	improve the quality of the service. The service was not managed in a way that the provider had considered necessary to care for people. Regulation 17 (1) (2) (a) & (e)
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had not ensured staff had received the training they considered necessary to meet people's physical and mental health needs. There were not enough staff on duty to ensure people received appropriate personalised care. Regulation 18 (1) (2) (a)