New Directions (Hastings) Limited

Bishops Gate

Inspection report

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Ratings

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

Overall summary

Bishops Gate is a care home providing residential care for up to eight adults with learning disabilities. In particular they provide residential care for people with Prader-Willi Syndrome (PWS).

This comprehensive inspection was undertaken on 18 and 22 December 2015 and was unannounced.

The service had a registered manager in post, however, they had not worked at Bishops Gate for approximately two months, and told us they were now working solely at a 'sister' home for which they were dual registered. '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. An acting manager had been appointed, with a view that they would register as manager once their induction was completed. Although the acting manager had been employed by the organisation for six weeks they had not

Summary of findings

been working full time at the location as they had been attending training. In the absence of the registered and the acting manager working at Bishops Gate, standards of care and documentation had not been maintained.

Medicine procedures were inadequate and we found a number of issues which meant that people's medicines had not been given to them as prescribed. Staff were making changes to doses of medicine based on verbal information from staff member to staff member, with no documented evidence in place to support the changes made.

Care plans and risk assessments had not been reviewed in all care files within designated timescales. There was a lack of clear and up to date guidance in place to support staff. Risks to people had not been well managed and supporting documentation completed when required. Protocols were not in place to give clear guidance to staff around one to one care provision and documentation for people was not person centred. Staffing levels at night had not been reviewed to address identified risks for people and it was unclear how these would be maintained at all times.

Maintenance checks to the building and equipment had not been completed appropriately.

Recruitment processes needed to be improved. Information regarding support needs for staff identified during interview had not been risk assessed and adequate support needs provided. Staff supervision had not taken place in accordance with the organisations policy and staff had not been adequately supported after incidents.

Good governance had not been maintained. Systems and processes were not carried out effectively. Provider and management audits had identified a number of issues. These had not been responded to in a timely manner to continually improve care delivery and ensure quality and safety within the service.

Staff were aware how to recognise and report safeguarding concerns. Staff had a good working knowledge of MCA and DoLS, with information available for people living at Bishops Gate in an easy read format.

Staff endeavoured to provide a safe and supportive environment for people, however this was not supported by adequate information, guidance, experience and a clear management system to ensure consistency at all times.

A varied activity programme was available for people. This included work placements, trips out and activities provided on site. People were also supported to participate in day to day household tasks to teach and support daily life skills.

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

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

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

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of 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 this 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?

Inadequate

The service was not safe.

Medicine procedures were not safe. The provider had not ensured people received their medicines in accordance with GP instructions.

Individual risks to people were not always identified to ensure people remained safe at all times.

Staffing levels at night did not ensure people remained safe at all times. Protocols were not in place to adequately inform staff how to provide care to meet people's individual needs.

Maintenance checks and fire risk assessments needed to be reviewed to ensure people's safety was maintained.

Recruitment processes were not robust.

Staff were aware how to report a safeguarding concern.

Is the service effective?

Requires improvement

The service was not consistently effective.

It was not always clear if people had been involved in care planning decisions, or how consent to care and treatment had been sought.

Inductions for new staff were not clear. Staff supervision had not taken place in accordance with the organisations policy. Staff had not received adequate support after incidents had occurred.

People's nutrition had not been clearly documented and monitored to ensure people's individual needs were assessed.

Information around training for staff was difficult to navigate. Staff told us that they had training but felt that they still required further guidance around managing challenging behaviours.

Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS)

Referrals were made to external health and social care professionals if required.

Is the service caring?

Requires improvement

The service was not consistently caring.

Systems to support and encourage people to be as independent as possible were not clear in their care files.

People's dignity was not always maintained.

Summary of findings

Staff knew people well and displayed kindness and compassion when supporting people.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care documentation had not been maintained to ensure it was clear, up to date and person centred to reflect differing support needs. One person had no information readily available to inform staff of their care needs.

A complaints policy was in place. However, complaints procedures needed to be improved.

A varied activity programme was available for people.

Is the service well-led?

Inadequate

Bishops Gate was not well-led.

The registered manager had not been working at the service and there had not been a consistent and clear management structure in place.

Incidents and challenging behaviour was not been responded to effectively by management and staff. There was a lack of clear and up to date guidance in place to support staff.

Systems and processes in place to improve the quality of care were not effective. Provider and management audits had identified a number of issues. These had not been responded to in a timely manner to continually improve care delivery and ensure quality and safety within the service.

Policies and procedures were organisational and not specific to the service.

Notifications had been completed for notifiable events.

Bishops Gate

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.'

This inspection which took place on 18 and 22 December 2015 was unannounced and was undertaken by two inspectors.

The last inspection took place in January 2013 where no concerns were identified.

Before the inspection we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and any other information that has been shared with us.

A Provider Information return (PIR) had not been requested as this inspection had been brought forward due to concerns. A PIR 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.

During the inspection we met and spoke with five people who use the service and eight staff members, this included care staff, the registered and regional manager, acting manager and deputy manager. There were no relatives or personal visitors to the home during our inspection; however, we received feedback from a relative after the inspection.

Not everyone living at Bishops Gate was able to tell us verbally about their experiences of living at the home. We carried out observations in communal areas, looked at care files for three people and a further two to look at specific areas of documentation. We looked at daily records, risk assessments and associated charts. All Medicine Administration Records (MAR) charts and medicine folders were checked. We read computer records regarding training and auditing, and looked at policies and procedures, accidents and incident reports, quality assurance records, meeting minutes, maintenance documentation and emergency plans.

Recruitment files were reviewed for four staff and further documentation for all staff regarding staff training, supervision and appraisal. We observed interactions between people and staff members to ensure that relationships between staff and people were positive and caring.

Inadequate

Is the service safe?

Our findings

We received mixed feedback from people regarding safety at Bishops Gate. We were told, "Yes generally I feel safe, but there are times when I don't." People and staff told us that incidents of challenging behaviour happened on a daily basis and there were times when this impacted on staff and people living at Bishops Gate. One person told us, "It makes me anxious when someone else is upset and shouting, its not one person that worries me its people's behaviour in general."

Although medicines were stored and disposed of appropriately, people's safety had not been maintained with regards to medicines. We looked at all medicine administration records (MAR) charts for people living at Bishops Gate and found that six out of seven had unexplained gaps when it was unclear if medicines had been given to people. We found no evidence that any staff had raised concerns with senior staff or managers regarding these discrepancies and staff were not aware whether medicines had been given or not.

One person had a prescribed medicated body wash, the MAR chart stated this was to be administered twice daily. There was only one signature on the MAR chart in the preceding month to show this had been done. Staff told us the body wash was now used every other day as the person had attended an appointment and the prescription had changed. Staff had not signed the MAR chart every other day to show they had been administering the medicine in this way and no information or documented evidence was found to support this change. Another person had eleven gaps over 18 days when a prescribed treatment had not been signed for on the MAR chart to show whether or not it had been administered. This meant that people were not receiving their medicines in accordance with their GP's prescription instructions. This could leave people at risk as medicine administration had not been maintained in line with current legislation and guidance.

Medicines had been incorrectly administered. One person had a prescribed pain relieving medicine. Their MAR chart stated 'two tablets to be given twice a day'. We checked the medication boxes which had been sent by the pharmacy which confirmed these instructions. The MAR chart identified that for at least two months this medicine had been administered as two tablets three times a day. This had been clearly signed for by staff when administered.

Staff told us they gave the medicine three times a day as they had been told to do this by a GP or the hospital after this person had attended an appointment. No evidence of this or any notes from previous hospital or GP appointments to evidence this change were found. Emergency notes and pen picture information completed by the staff (in the event of hospital admission) were incorrect and stated two tablets three times a day. This was raised as a safeguarding alert during the inspection and staff were advised to contact the persons GP. It was later confirmed by the GP that this medicine was prescribed as stated on the MAR chart 'two tablets twice a day'. Senior staff told us that this error had been identified during an 'In house' audit before the inspection; however staff had continued to administer the medicine incorrectly. Another person had a newly prescribed anti-inflammatory cream; this had been started on the day of the inspection. We asked staff to tell us what the medicine was prescribed for. One staff member told us this was for the person's arm and another for their knee. No information was on the MAR chart to inform staff of the correct place to apply. We asked staff to contact the GP to ensure that the correct information was available and this was done during the inspection. The identified shortfalls meant people's health and safety had not been maintained by the proper and safe management of medicines.

Some medicines were 'as required' (PRN) medicines. People shoud be offered these medicines if they need them, for example if they were experiencing pain. We found there was no clear PRN guidance in place. PRN protocols had been written for some people and we saw that improvements were in progress to ensure PRN medicines were given correctly. This needed to improve to ensure people received medicines in a clear and consistent manner regardless of who administers them.

Individual risks to people due to their health, support and care needs were not always identified to ensure people remained safe. We saw limited information in individual care files regarding behaviours that may challenge and how this should be safely managed by staff. Care information and risk assessments had not been completed or updated regularly to ensure that people remained safe at all times. We found that when issues of concern had been identified, this had not led to appropriate risk assessments being completed and a review of all care and support needs. This meant that it was unclear how people were protected from risk of harm at all times. One person

Is the service safe?

required one to one support when they were not in their room. There was no clear protocol in place to inform staff how one to one support should be provided. We asked staff to tell us how they provided one to one support for people and it was clear that staff interpretation of this varied. Alarm systems were in place to alert staff when some people left their rooms. However at night there was only one member of staff working at the service. The provider and registered manager could not evidence how one member of staff at night would be able to provide support to people to ensure everyone remained safe at all times. For example, people who had an identified risk when they left their rooms needed to be provided one to one support. It was also unclear how one staff member would be able to safely respond in the event of an incident occurring or an emergency evacuation.

A fire risk assessment and personal emergency evacuation plans (PEEPS) had been completed. This was in a 'grab folder' in the main hallway. However, we found that fire evacuation plans had not been updated. Information about people's one to one support and other risks had not been included. This meant that in the event of an evacuation, relevant information about people's safety was not in place regarding current risks. It was not clear how current staffing levels at night took into consideration risks to people and how these would be safely managed in the event of an emergency evacuation.

Risk assessments were in place for people who attended activities and work placements. We saw that one person was able to go out alone to buy a newspaper. However, this decision had not been clearly reviewed since August 2015 and information around decisions was not clear. It was therefore difficult to see how decisions had been made and reviewed appropriately to ensure they remained safe to continue.

Bishops Gate provides care for people with Prader Willi Syndrome (PWS). The organisations PWS policy stated 'there may be serious health implications for service users if weight management is not acknowledged and planned effectively'. Monitoring of people's weights had not been reviewed to ensure people had been weighed in accordance with their care documentation. We found some weights recorded in people's care files and some in MAR folders. One person had no weights recorded since October 2015, despite care documentation stating that their weight needed to be monitored weekly. Staff told us the person had declined to be weighed although this had not been documented anywhere. This meant that the provider had not ensured peoples care was provided in a safe way to mitigate risk and identify changes to health. Care plans for PWS stated that people should have targets and goals to maintain a healthy weight. We found that goals had been set in some care files, however not regularly updated or reviewed.

Although maintenance plans were in place for overall refurbishment of the building. We looked at how the service ensured the premises, services and equipment were adequately maintained. Maintenance folders were disorganised and staff were unsure if recent checks had been completed and were unable to locate recent documentation. They told us that most maintenance information was held at the organisations head office. The registered and acting manager were unaware if copies were available at the location. For example legionella, gas safety and electrical PAT testing certificates, although copies of these were sent through from the head office at our request. Maintenance checks which should be carried out at the service, for example water temperature and window restrictor checks had not been done regularly. Monthly sheets completed by staff contained gaps when they had not been completed. When checks had identified that water temperatures were not within specified safe temperature levels, no evidence was documented to show what actions had been taken. The above issues meant that people's safety and welfare had not been maintained. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered and acting manager told us there were set staffing levels for day and night time. Staff turnover had been high. The registered, acting and deputy manager told us that a number of experienced staff had left the service in recent months. A process of recruitment was on-going and some new care staff had been employed. We reviewed staff recruitment files. Management at Bishops Gate did not have access to a number of relevant documents which they needed to ensure they knew staffs background and whether appropriate checks had been completed before they started work at Bishops Gate. We found that although records were kept of interviews, these were not detailed and sections were left blank. People living at the service were not involved in the interview process and it was not evident whether or not prospective staff had the opportunity to visit the home or to meet any of the people

Inadequate

Is the service safe?

living there before starting work. A gap in one staff member's employment history was recorded and a reason provided by the applicant but it was not evident that this had been discussed with them. Two staff had highlighted health and support needs during their application process. These were areas they would require support with. However, no risk assessment or guidance was recorded to show how reasonable adjustments would be made to ensure this was possible.

We were told that disclosure and barring checks (DBS) had been carried out but there was no record in each file to confirm this. Records relating to DBS checks are held at the providers head office. These checks identify if prospective staff had a criminal record or were barred from working with people. Audit records confirmed that DBS checks were in place for all but a few staff that had not had a new check undertaken when the new provider took over the company. One person had declared a caution/conviction on their application form. The section on the interview form to discuss this had been left blank. We saw a completed induction checklist in one file. We were told that staff had started a 12 week induction but that individual staff members kept their own file. We did not see any system to monitor or keep track of staff progress in this area. The manager could not tell us whether or not staff had completed inductions, or how the provider ensured all staff employed had the appropriate qualifications; competence, skills and experience to ensure people receive safe care and treatment. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered and deputy manager were aware of the correct reporting procedure for any safeguarding concerns. Staff demonstrated a good knowledge around how to recognise and report safeguarding concerns and told us they could also contact the registered or regional manager if they had concerns. Staff told us that they had training around safeguarding and information was available around the service to inform people of actions to take if they suspected abuse.

Requires improvement

Is the service effective?

Our findings

People told us most staff knew them well. One said "I like them the ones who have been here a while, the new ones don't know us so well, its takes a while." Others told us, "There's a lot of change, I don't know everyone."

Staff were open and honest about the challenges they faced working at Bishops Gate. Staff all told us they loved working with people, but found there was a lack of consistency and support from the provider.

The organisations policy relating to staff supervisions stated that supervisions would be provided every eight weeks. A schedule for staff supervision had not been maintained, staff told us that there had recently been group supervision and the acting manager told us they had carried out some individual supervisions, however these had not yet been documented. We saw a record that group supervision for six staff had been held in September 2015. We were told that the frequency of supervisions had slipped but that all staff who attended the last team meeting in December had attended a group supervision meeting. Ten of the eighteen staff had signed that they had attended. We saw an individual supervision record for one staff member only and although it stated that the meeting lasted an hour there was limited information recorded about the meeting. Staff we spoke with told us they had not received supervision recently. All staff felt they could speak to someone if they had any concerns but not all were aware who had overall responsibility for the service at that time. Staff told us they did not receive any feedback or support after incidents. One staff member told us they had been involved in an incident when they had been hit by someone living at Bishops Gate. We found no evidence that the staff member had received support or debrief with no reference to this incident in their staff file. We spoke to the registered manager who confirmed that an incident had taken place. This meant staff had not been offered and received adequate support after incidents. Therefore the provider could not be sure that staff had the appropriate support to ensure they met peoples need effectively.

We were told that new staff completed a period of induction. During the inspection we were unable to evidence any induction information as the acting and registered manager told us staff kept these with them. It was therefore unclear how management at Bishops Gate knew what areas of the induction had been completed for new staff and whether any areas had been identified for further training or support.

Staff told us, "Something happened today; I thought I was ready to take people out alone, but I think I need more experience, or someone to come out with me when I take people to activities." We spoke to staff who had worked at Bishops Gate for over six months. One told us. "I think we all need more training around challenging behaviour, it happens every day." And, "You need to know other staff can help you, that's difficult when you are working with someone new." We saw that a lack of experience and guidance was apparent when two incidents occurred during the inspection; this meant that people did not receive care from skilled and experienced staff to meet their care needs. We looked at training records, these were on a computer and it was difficult to navigate the system to get an overview of training attended and when it was next due. The registered manager told us they were made aware by the head office when training was due and they looked through the system to see who needed to attend. The acting manager had been unable to access all information as they had been awaiting log in details for the computer system used by the organisation. The registered manager told us they were unable to see at a glance who had attended a specific training without logging into the system and looking at each staff members training record individually. This meant it was difficult to get an overall picture of who had attended training and on what date to ensure all staff were adequately trained. Future training had been booked and information regarding this was available. Staff told us that they were usually told when they had training arranged, but this could be short notice. Newly appointed staff told us they felt supported to provide care and support to people. However, they felt they needed to work alongside experienced staff to ensure they had continued support when situations became challenging. These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monitoring of peoples nutrition was not clear. People had PWS care information in their care files regarding nutrition and calorie controlled meals. However, this was generic and not based on people's individual health needs. Every care file we looked at contained the same PWS information and staff told us meal sizes were the same for each person.

Requires improvement

Is the service effective?

Although support plans stated meals were to be calorie controlled we did not see that this had been assessed for the individual. For example, some people had health related conditions and some were more physically active throughout the day. Staff showed us an organisational dietary analysis of menus. This included menu choices and nutritional values for each meal but it was unclear how this was used in practice to monitor people's individual nutritional intake. Staff told us that people regularly went out accompanied by staff. Trips could incorporate going to a pub or café/restaurant to eat a meal or have a drink. It was unclear how this was included in people's daily calorie controlled intake and where or how this was documented or monitored. Staff assisting in the kitchen told us everyone had the same portion sized meals. Therefore it was unclear how people's nutritional needs were individualised. Care documentation stated that people with PWS required calorie controlled nutrition. Peoples' calorie intake and nutrition had not been monitored individually other than when weights had been documented. People's nutrition was not monitored effectively. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was limited information to show people had consented to support plans. We saw that when people had signed care plans or risk assessments these had not been regularly reviewed and some information was no longer up to date or relevant. Care files did not show how people, families and significant others had been involved in decisions or when changes to care had taken place. We saw one file where a person had signed some of their support plans; however a number of these were out of date and had not been reviewed in recent months.

Staff had an understanding with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty. Protecting people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option. The registered and deputy manager understood the principles of DoLS, how to keep people safe from being restricted unlawfully and how to make an application for consideration to deprive a person of their liberty. The registered manager had followed correct processes and made referrals when needed. Staff understood why people may require DoLs to be in place and that this may place specific restrictions on them. For example, restrictions in place regarding people's access to food items and money in relation to PWS. MCA and DoLS information was displayed on notice boards and available in easy read format for people living at the service.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs and health related appointments. On the day of the inspection one person was being taken to an appointment. They told us, "I have to have an injection, I hate needles so someone is coming with me." After they returned from the appointment they told us, "It was all sorted, they went in first and spoke to the doctor so I did not have to look at the needle, they really sorted it and I was fine."

Requires improvement

Is the service caring?

Our findings

Staff told us, “I love working here, I love caring for people, the residents are great.” And, “We try to support each other, but it’s been difficult lately as there are so many changes.” People told us, “Staff care, I like them.”

Despite positive feedback we found some areas of care which did not respect people’s dignity.

Medicines were given to people from the medicine cupboard which was located in a small office in the corridor as you entered the building. This room was used for storing care documentation and used by staff throughout the day as it contained the telephone and computer. This meant that when people took their medicines this was not done discretely as the office had windows on all sides. People were in constant view even if the door was closed. We saw that people were aware of times for medicines to be given and began to congregate in the hallway. This gave an institutional feel and did not protect people’s privacy and dignity. This was an area that needed to be improved.

Systems to support and encourage people to be as independent as possible were not clear in documentation. Care files stated people ‘wished to be as independent as possible with finances’ or ‘needed help with budgeting’ but it was unclear how this as being done. Short term goals had not been updated to give an up to date picture of peoples individual goals and how these were being evaluated and reviewed. This was an area that required to be improved.

We saw that people responded well to certain staff and there was an obvious trust between some staff and people which had been built up over time. One person was being supported to an appointment and another being assisted with an activity. People appeared happy and relaxed when support was provided.

The acting manager told us that people’s rooms were their private space and staff should not enter people’s rooms without the person present or their consent. People were able to lock their bedroom doors and staff asked permission before they entered people’s rooms. People were able to access their rooms and spend time in the communal areas as they chose.

The inspection took place just before Christmas and a number of people were preparing to go and stay with family. For those who were staying at the service, staff told us that activities were planned; with people spending time Christmas day together from the other ‘sister’ homes to ensure that people were not isolated over the Christmas period.

Requires improvement

Is the service responsive?

Our findings

People with PWS had varying degrees of support needs. Some people required one to one support throughout the day whilst others were able to go out alone for short periods of time for specific activities. We looked at three people's care files in full and a further two to look at specific areas of documentation. Care plans lacked person centred detail on how to support and provide care for the individual. Many care plans were generic and although some personal information had been included, overall care documentation was not person centred. Documentation did not provide staff with person centred information to ensure people received care to meet their specific needs.

People may be put at risk if documentation is not always complete and accurate. Care documentation had not been maintained effectively to ensure that it was fully completed and reviews undertaken in stated timescales. Short term goals were not reviewed with people to ensure they remained current and specific. When people attended an appointment documentation had not been completed to ensure all staff were aware of the outcome. When safeguarding concerns had been raised, this had not led to full to reviews of documentation in people's care files to ensure staff had appropriate guidance in place. Poor documentation puts people at risk of receiving inappropriate care and treatment.

The acting and deputy manager told us that one person did not have a care file in place to inform staff of their care needs, as this person kept the file in their room and would not allow staff to access it. It was unclear how current and newly employed staff were able to ensure they met this person's care and support needs. The registered manager told us that there was documentation for this person on the computer, however this had not been fed back to the acting and deputy manager who had been in day to day charge at the service for the last two months. As such this documentation had not been accessed or updated in this time. This meant that an accurate record of care delivered, decisions made and reviews of care had not been completed.

We saw that incidents were responded to in a disorganised way with no forward thinking or discussion. This meant that people living at Bishops Gate were given conflicting information. For example, one person was seen to be upset that an activity had been cancelled at short notice. This sudden change to the daily plan had caused a high level of anxiety for the individual and an incident occurred where they displayed challenging behaviours. On discussion with the manager this could have been avoided with some minor logistical changes to ensure the person could still attend the planned activity.

This incident was witnessed by other people living at Bishops Gate and they told us, "When people shout and are upset this makes me feel anxious." They also told us that these incidents happened on a daily basis. We looked at care files. We found that documentation was not in place to ensure staff were aware how to support people and respond appropriately to individuals challenging behaviour.

These issues meant that the provider had not ensured people had accurate, contemporaneous records maintained in relation to their care and welfare. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints policy was available. People told us if they had something they were not happy with they would tell someone. Written complaints received had been responded to, however not all issues raised with the service via email had been identified as formal complaints and we were told these were just 'issues raised'. Although the acting manager was able to show us emails sent in response, not all conversations and actions taken had been clearly documented within the complaints procedure to ensure that a clear audit trail had been maintained. When complaints had been closed it was not clear when this had been completed or what information had been fed back to the complainant to inform them the complaint was concluded. This was an area that needed to be improved.

People told us they knew what they were doing each day. There was a daily schedule of activities included in people's personal activity planner. This included work placements, trips out and daily activities available at the on-site day centre. People told us they enjoyed the things they did. One told us, "I like horse riding, I would go every day if I could." And another said they liked the time they spent with animals. One person had pets which they were responsible for. Staff supported this person to ensure that the animals were well cared for every day. People also had a 'house day' included in their activity plan. House days included cleaning, hovering their room and communal areas, washing and drying their clothes if appropriate. People

Requires improvement

Is the service responsive?

were also encouraged to help with food preparation. One person told us, “I enjoy peeling and chopping the vegetables, It is a good thing to do.” This meant that people were encouraged to participate in everyday life skills when possible.

We saw that the service statement of purpose and some policies and information displayed around the building was provided in an easy read format for people to access if they wished.

Inadequate

Is the service well-led?

Our findings

There was a lack of consistent leadership at Bishops Gate. The registered manager told us they had not worked at the service for two months and were now working full time at another home belonging to the provider. The newly appointed acting manager although employed by the organisation for six weeks had not been working full time at the location as they had been attending training. In the absence of a registered or acting manager working at Bishops Gate, it was not clear to staff or people living in the service who was taking overall responsibility for the day to day running of the home, who staff should report to, or who was responsible for decision making.

There was no clear support system in place for acting and interim managers to ensure a consistent management and leadership to support staff and ensure standards of care were maintained. People and staff spoke to us regarding the changes to the way the service was run since it was taken over by a new organisation. This had led to a number of staff leaving and staff changes. Staff told us this had caused anxiety amongst staff and a negative staff culture was affecting residents. Staff told us the home had changed since it was taken over by Craegmoor. Staff and residents told us they had no idea who was in charge on a day to day basis. However, all staff were committed to providing good care for people to enable them to live fulfilled and happy lives.

Staff felt that communication was poor, and this meant that they did not always feel supported when communicating with people using the service. Staff felt that they were not told about changes to management and did not always know who to go to when there was an issue. Senior staff told us that the care staff had been 'left to get on with it over recent months and were doing their best' and 'they needed better consistent management to ensure that they were supported'. The lack of a clear chain of support had led to inconsistency and differing advice. Staff told us, "You get told to do one thing by one person, then something else by another." We saw staff interacted in a positive way with people; however staff lacked guidance and support to make appropriate decisions regarding response to incidents.

We looked at incidents of challenging behaviour by people living at Bishops Gate and how these were responded to by management and staff. We observed two incidents during the inspection and saw that these were not well managed. Staff lacked guidance and there was a lack of communication between staff on all levels.

Whilst there had been no registered manager working at the service, support had not been in place to ensure that standards of care and documentation had been maintained. The provider had not ensured that a clear support system was in place for acting and interim managers to ensure consistent management and leadership was in place to support staff and ensure standards of care were maintained. This meant that issues had not been identified and responded to in a timely manner.

We looked at staff meeting minutes. It was noted that in September 2015 several staff had raised concerns about the home and sought support in how to manage behaviours that challenged. A discussion was held about the behaviours and staff were given reassurance. A separate action plan detailed the actions to be taken as a result of the meeting. The timescale for achieving the actions mainly stated 'ongoing'. An action from a previous meeting related to a concern that care plans had not been completed and evaluations not being consistent. The timescale for this was immediate. However, both areas had still not been addressed sufficiently to ensure staff felt supported and documentation was in place. Minutes also refer to staff being anxious about coming to work. This showed that when staff raised concerns and although discussed no definite action was detailed as having taken place.

Policies available were organisation generic and not policies specific to the service, people living at Bishops Gate and the staff. For example, the challenging behaviour policy was generic with nothing broken down as a local policy and a number of policies related to supported living which was not appropriate for this service. Some policies were displayed, including MCA, DoLS and safeguarding. Policy folders were disorganised and some policies needed to be replaced with up to date versions. The folder had no index to help you locate specific policies when needed.

The regional manager had carried out compliance visits to the service. We saw that issues had been identified at previous visits and in audits. For example, that peoples

Inadequate

Is the service well-led?

care reviews had not been completed. This information had been sent to the provider, however, no action had been taken to rectify the issues identified and these had been carried forward and identified again in future audits.

Care documentation had not been audited to ensure that it was fully completed and reviews undertaken. For example, care documentation was not updated sufficiently in response to safeguarding concerns and risk assessments needed to be reviewed and updated. An 'In house' medication audit had been completed just before the inspection and appropriate actions had not been taken in response to issues found.

A number of audits and quality reviews completed by the provider identified issues and an action plan had been devised, this included a 'practice' CQC inspection which had identified areas of concern. However, actions were not appropriately assigned to people to ensure they were responded to in a timely manner.

These issues meant the provider did not have systems in place to assess, monitor or improve the quality of services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications had been completed when required. The registered and regional manager both displayed a good knowledge of when and how notifications to the CQC or other outside organisations were required. Information was available regarding 'duty of candour' and the registered and acting manager were able to tell us how this would be followed and actions that would be required to ensure the organisation was open and transparent.

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	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 of the HSCA (RA) Regulations 2014 The provider had not ensured all staff employed had the appropriate qualifications; competence, skills and experience to ensure people receive safe care and treatment. Fit and proper persons employed. 19(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured sufficient qualified, competent, skilled and experienced staff were deployed to ensure people's needs were met at all times. There were no clear support systems in place for staff. Staffing 18(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Peoples nutrition had not been effectively managed. Safe care and treatment 12(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems in place to assess, monitor or improve the quality of services provided. 17 (1)(2)(1)(a)(b)(c(f)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Safe Care and Treatment People did not received medicines in a safe way. The provider had not ensured peoples safety and welfare at all times. 12 (a)(b)(d)(g)(i)

The enforcement action we took:
Warning Notice