Real Life Options

# Real Life Options - 120 Lichfield Road

**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

This inspection took place on 3 September 2015. The inspection was unannounced.

Lichfield Road is a residential home, where care and support is provided to five people who have learning disabilities or have mental health support needs. There were five people living in the home at the time of the inspection.

The accommodation was provided in single bedrooms; the home had bedrooms and bathrooms on the ground and first floor. There were shared lounges and dining facilities available on the ground floor.

At the time of this inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal

# Summary of findings

responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A newly recruited manager was present during part of our inspection.

People living at Lichfield Road could not be confident that the registered provider would be able to keep them safe. This included the arrangements to make sure staff responded appropriately in the event of a fire occurring at the home. People were placed at the risk of infection from poor management arrangement of clinical waste and were not fully protected as we saw unclean bathroom and shower facilities.

There were not enough staff to meet personal care needs of people in a timely manner or to accompany people to go out of the home should they have chosen to go out at the same time, this restricted people's choices.

One person told us they were happy at the home but other people were unable to verbally share their views about their experience living in the home.

We saw some undignified and uncompassionate practice, and staff we spoke with did not demonstrate a positive regard for the people they were supporting. We saw staff treating people with limited respect and did not communicate well with people who did not use verbal communication. We saw examples of staff not following the instructions in people's care plans, for example during meals, and this placed people at risk.

New staff had not all been provided with an induction that would ensure they knew how to care for people and would ensure they could work safely. Not all of the staff had been provided with all of the training they required or with regular supervision.

There was a complaints process; however the provider did not convey openness to receiving or acting on complaints. Whilst people did advise they would raise concerns with staff people did not know how to raise a formal complaint or did not know who they would contact. There were no records to evidence any complaints being received or acted on.

At the time of our inspection a new manager was new in post, and there were no other senior staff working at the home. It was not evident that the governance system (ways of checking the safety and quality of the service) in place in the home or operated by the registered provider had been effective.

We found the provider was in breach of Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

# 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**

People were not safe.

People who used the service were placed at risk because the provider did not have safe systems in place to manage and reduce the risks associated with their care needs. The numbers of staff on duty were not able to meet peoples needs.

People were at risk of infection due to poor arrangements for management of clinical waste and ensuring that the home was clean.

Some aspects of medicines management needed improvement.

**Is the service effective?**

**Requires improvement**

The service was not effective.

Not all staff had received training in topics that were relevant to the needs of people using the service. Staff were not effectively supported or supervised.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld.

**Is the service caring?**

**Requires improvement**

The service was not consistently caring.

Staff practices demonstrated that they had no respect for people's dignity or privacy.

We saw poor interactions between staff and people who lived in the home.

**Is the service responsive?**

**Requires improvement**

The service was not always responsive to people's needs.

Care plans and assessments did not always adequately guide staff so that they could meet people's needs effectively.

Arrangements for people to be able to participate in activities they enjoyed needed to be improved.

The provider did not convey openness to receiving complaints and people and relatives would not know how to make a formal complaint.

**Is the service well-led?**

**Inadequate**

The service was not well led.

There was no registered manager at the home.

The lack of effective management placed people at risk of harm.

# Summary of findings

The systems in place to check on the quality and safety of the service were not effective, and had not ensured people were benefitting from a service that met their needs.

# Real Life Options - 120 Lichfield 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.

This inspection took place on 3 September 2015 and was unannounced. The inspection team comprised of two inspectors.

Before the inspection we looked at the information we already had about this provider. We looked at information received from the local authority and the statutory notifications the provider had sent to us. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During the inspection we met with all of the people who lived at the home. Some people's needs meant they were unable to verbally tell us how they found living at Lichfield Road, and we observed how staff supported people throughout the inspection. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with the newly appointed services manager, one agency staff, and three care staff. We looked at the care records of two people. We spent time observing day to day life and the support people were offered.

Following our inspection we spoke with the relatives of five people and two health and social care professionals. The registered provider sent us further information which we had requested and this was used to support our judgment.

Inadequate

# Is the service safe?

## Our findings

The management of risks to people was not adequate and failed to protect them during the course of everyday activities of daily living.

Two people had been assessed by health professionals as being at risk of choking and they had been told not to eat certain foods. During our visit we saw staff gave one person a type of food that had been identified as a risk to the person. We asked three members of staff if any people living at the home were on special diets or at risk of choking and they were inconsistent with their responses. Whilst there were clear records in the persons care plan about what foods were to be avoided. This did not give us assurance that all staff were fully aware of foods that were a potential choking risk.

Staff we spoke with knew how to report any allegation or suspicion of abuse. We explored staff knowledge in relation to potential signs and symptoms of abuse and staff were able to describe this in detail; however some staff practices we saw did not protect people's dignity and respect, which could result in emotional harm. There was no system in place for logging safeguarding incidents or notifications for follow up at the home or with the local authority.

We were not assured that risks to people's safety was being well managed. We saw that cupboards containing hazardous cleaning materials were not kept locked. A member of staff told us this was because the lock was broken and they had intended to move the substances the previous day, but were unable to because they were busy supporting people. We brought this to the attention of the newly recruited manager. We saw that all the garden furniture in the bottom garden was broken, during our visit we saw a person who lives at the home accessing the garden independently; this meant people were at risk of sustaining an injury.

We spoke with care staff about the procedures they needed to follow in the event of the fire alarms sounding. The majority of care staff were fairly confident in the procedures they needed to follow. One member of staff who had undertaken the role of a shift leader did not know what the fire procedure was, and did not know where the fire assembly point was. This was of concern as it could impact upon the safe evacuation of people from the premises. We looked at the records for testing the fire alarms. Care staff told us this should be done weekly but the records did not show this had been checked since April 2015. We brought this to the attention of the newly recruited manager who instigated a test during the day of the inspection. We saw that the fire risk assessment for the home was out of date.

On the day of our visit one member of staff was left in the home to support a person who required two to one support to move from their chair or to move around the home. In the event of a fire or other emergency the person would have been at risk of not being supported to safely evacuate the premises.

People were not provided with a clean and safe environment to live in because staff did not take appropriate action to keep the home clean. We were advised that night care staff were responsible for cleaning the home and that they had a schedule of tasks to complete. In the communal shower we saw tiles that were discoloured and mould was noted to be visible between the tiles. The shower room was generally dirty with an offensive odour of mould evident. In the communal bathroom, we saw that the underside of the bath seat was dirty and stained with no evidence that it had been cleaned. The lid was missing off the clinical waste bin which contained used waste. At the front of the property we saw that the clinical waste storage bin was overflowing with clinical waste bags. We asked staff if the home had an infection control lead and if so, who this was. None of the care staff we spoke with were aware of the home having a named member of staff who took responsibility for leading on infection control prevention or associated issues.

A relative we spoke with told us, "The side of the property is a disgrace and the clinical waste bins are always overflowing".

Failing to provide safe care and treatment is a breach of the Health and Social Care Act 2008(Regulated Activities) 2014. Regulation 12.

We saw that sufficient supplies of personal protective equipment such as gloves and aprons were available for staff to use and these were used by care staff during our visit. One member of staff told us that on occasions supplies of these had run out.

One person who lived at the home was able to tell us in detail about their experience of living at the home, they told us, "Yes, I feel safe here and nothing frightens me". A relative we spoke with told us, "I think [name of relative] is

Inadequate

# Is the service safe?

safe enough, I just do not think there is enough staff ". Staff we spoke with told us that the potential risks to people who used the service had been assessed and action had been planned and taken to keep people safe, however, records we saw did not support this, the majority of risk assessments were not dated and there were no arrangements for continually reviewing significant changes to people's needs. One person's risk assessments were all in relation to their previous home and not their current home, this meant the person's care and support had not been managed to ensure they were protected from avoidable harm.

Staff we spoke with told us they were aware of the importance of reporting and recording accidents and incidents. Records we saw did not support this; accident and incident records were not clearly recorded with outcomes detailed. Staff could not describe plans to respond to all emergencies. One person was living with a health condition that was not clearly recorded in their care plans and staff we spoke with were inconsistent with how they would support the person in the event of an emergency.

The provider had a whistle blowing hotline but most staff we spoke with were unsure if the provider had a whistle-blowing hotline that they could use to report any concerns to. Staff were not openly encouraged and supported to raise any concerns they may had. We saw there was no information available regarding how to raise concerns or to direct staff to follow the whistleblowing procedure.

During the inspection we observed transfers and moving and handling techniques not being completed in a safe manner which could impact on people's safety. For example; we observed a wheelchair being used without the use of footrests and we intervened to ensure that the person did not sustain an injury from the action witnessed.

The majority of staff we spoke with raised some concerns about staffing arrangements in the home but told us staffing levels were usually safe and that the use of agency staff had reduced. Several staff told us that an extra staff was needed due to people's needs and in particular one person needing two to one support. On the day of our visit one member of staff was left in the home to support a person who required two to one support, this meant that if the person required support they would not receive it or in the event of a fire the person would be at risk of not receiving a safe evacuation.

We looked at the staff rota and this showed that during the week of our visit there was no manager or senior staff working at the home. The rota indicated that for each shift there was a shift leader. Staff told us that the member of staff that did the "sleep-in duty" shift was the designated shift leader for that particular day.

A relative we spoke with told us, "I have been asked on a number of occasions to accompany [name of relative] to hospital and doctor appointments because there is not enough staff on duty". One relative told us, "There is not enough staff, too many agency staff and not enough experienced staff to meet the needs of [name of relative] condition." Another relative told us, "There is never enough staff on duty to look after everyone".

We looked at the way medicines were stored, administered and recorded. Care staff told us that medicines were only administered by staff who were trained. Staff told us they could not remember undertaking any competency tests for administering medication. There were suitable facilities for storing medicines.

We observed medication being given and saw that two staff checked the medication records before administering any medication. Most medication was in blister packs. The records of the administration of medicines were completed by staff to show that all prescribed doses had been given to people. For one record we were unable to find guidelines for staff with clear instructions on what dose to give people; this meant some people may have been placed at risk of receiving the wrong dosage of medication.

We saw that some medicine protocols were not in place for medicines that are prescribed for "use as needed" (PRN) this meant some medicines could be at risk of being administered incorrectly. There was a photograph of people adjacent to their medication record to help reduce the risk of medication being given to the wrong person.

Requires improvement

# Is the service effective?

## Our findings

We looked at the induction arrangements for staff who were new to the home. There was inconsistent support for new staff during their induction period. One member of staff we spoke with told us, "Yes, I had an induction, I looked at policies and procedures and did some shadowing (observing more experienced staff) with other staff". Another member of staff told us, "I did not have any formal induction, I just got shown around and looked at some policies and procedures".

We spent time talking with staff about how they were able to deliver effective care to the people who lived at the home. The majority of staff we spoke with told us they were not supported and training was limited. We received some mixed opinions from staff about the training offered to them. Staff comments included, "I've been here for a year and have not received any training"; "We have little training here"; and another staff member said "Yes we do have some training".

We asked staff if they received regular supervision. Supervision is an important tool which helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The majority of staff we spoke with told us they had not received regular or recent supervision. Comments from staff included,, "I have worked here for 12 months and have never had any supervision". Staff who did recall having supervision said "I've had one supervision session in the last 14 months" and the second person said "I had supervision about two years ago".

A person who had been identified as in need of support from two staff at all times was unable to sit at the dining table or eat their lunch when other people did because there was not sufficient numbers of staff available to support them with moving and handling transfers so that they could move to the dining table. The person was left to sit on their own in the communal lounge area and although they could see other people eating their meals they were not offered any food or supported, reassured or diverted in any way whilst they waited for staff to return so that they could be assisted.

Failing to provide staff in suitable numbers and with suitable skills and experience is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18.

Staff we spoke with had not been provided with training and were unable to describe their responsibilities under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). We looked at whether the provider was applying the Deprivation of Liberty Safeguards (DoLS) appropriately and that any restrictions were appropriately assessed and authorised. Discussions with the service manager identified that there was no clarity that necessary applications to the local supervisory body for Deprivations of Liberty Safeguards (DoLS) had been made.

We did not see any examples of staff gaining people's consent. The majority of people at the home had alarms on their beds that alerted night staff to them getting up or being incontinent. People were unable to tell us if they had consented to their use and care records did not show evidence of consent or decisions being made in their best interest. Staff we spoke with were not sure if best interest decisions had been made as they told us this equipment had been in use for some time.

One person had been admitted to the home six months ago from another establishment within the organisation. Staff were unable to tell us if they had consented to the move and care records did not show evidence of consent or decisions being made in their best interest. A relative we spoke with told us that the move had been well-planned by the staff at the home the person was moving from.

Staff told us they received handovers from the designated shift leader before they started their shifts and said communication was good within the team, however the arrangements had failed to ensure that information about specific care and support needs of people were known by all staff. . Staff told us that people had access to a wide range of different food and drinks. One person we spoke with said, "The food is nice, I make my own breakfast". We observed drinks being offered to people throughout the day, and one person told us that they had plenty to drink.

It was clear from the observation we undertook at lunch time that mealtimes were not relaxed or a pleasurable time for social interaction, we saw a person being supported with their meal in a rushed and undignified approach. The

Requires improvement

# Is the service effective?

pace at which one person was assisted was very fast and support failed to be delivered at a pace which suited the person. People we observed were not offered a choice of where they preferred to eat their meal or what they preferred to eat. Some people were independent during mealtimes; however, there was no communication between people and staff during meal times. we witnessed support being provided with no communication between staff and people using the service.

Staff told us that the menus were flexible and that alternatives were always available if people did not want what was on offer. Staff were not aware of all the risks to people with complex dietary needs. We asked staff about support provided to one person who required their food to be fortified and we received mixed responses about the persons dietary needs with no clarity or assurance that the persons needs had been met.

We found some evidence that people had been supported to attend a range of health related appointments in relation to their routine and specialist needs, but the arrangements failed to provide any assurance that people were consistently supported in respect of meeting their healthcare needs. We saw that a record was being kept of professional visits, such as GP and dieticians. We saw in one person's care plan that they had refused to go to a dental appointment, we asked staff what had happened to support the person to make an alternative appointment, staff told us they were unsure. Relatives we spoke with told us, "Communication is poor, I'm never told if [name of relative] has been to the doctors or dentist".

Some people's care plans recorded that they needed to be weighed monthly to help ensure they were at a healthy weight. One member of staff told us this was not being done. We saw in one person's care plan that following a recent nutrition and swallowing assessment, they had gained sufficient weight to be discharged from the service. Following the inspection we spoke with two health and social care professional who told us, "Staff worked with [name of relative] and have supported them to meet their individual targets"; "Staff did not cope well the [name of person] at the onset on their admission, but it is more settled now, there is quite a high turnover of staff which means I can't always talk to permanent staff".

Requires improvement

# Is the service caring?

## Our findings

We saw limited communication between people and staff .Some people were able to talk to staff and explain what they wanted and how they felt. Other people needed staff to interpret gestures or to understand the person's own methods of communication. People's plans contained person centred guidance for staff about how to communicate. One person's care plan stated that the use of communication cards was a preferred way of communicating, however we did not see this being used or offered and staff we spoke with told us communication cards were not used; this meant people were unable to communicate and make themselves understood. Relatives we spoke with told us, "I have concerns about the lack of engagement between staff and the people who live there"; "Staff do not talk to [name of relative], people just sit there and watch TV all day".

A person who needed two to one support was unable to sit at the dining table or eat their lunch when other people did because there was not sufficient staff to support them with moving and handling transfers. The person sat on their own in the communal area and could see another person and a member of staff eating their meals. It was apparent that the person required support with their personal care, this did not happen because there was not sufficient staff to support them with moving and handling transfers. Staff did not show concern for the person's well-being in a caring and meaningful way. When there were sufficient staff available to undertake the moving and handling transfer the person was not offered a choice of personal care prior to eating their meal; which meant no action was taken to relieve the person's discomfort. They were not provided with support to maintain their dignity, and they were not provided with choice or enabled to make a decision about what they wanted to eat.

We observed a moving and handling transfer with the use of a hoist, there was no interaction between the staff and the person during the manoeuvre; the activity was undertaken as a task with inadequate regard for the person being supported.

We asked care staff what they did to protect people's dignity and privacy and whilst all the staff we spoke with were able to describe how they did this, however, we did not see examples of this in practice. There were numerous occasions witnessed when personal information about people was spoken about in front of others living in the home, visitors to the home, and other staff. The information shared compromised the dignity of people using the service.

Failing to provide people with dignity and respect is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 10.

Some opportunities were available for some people to take part in everyday living skills. One person told us "I like to keep my own room tidy." During our visit we saw examples of one person making themselves a drink and their breakfast.

Some people made some choices about what they wanted to do and where they wanted to be. We saw people walking round the home and the garden. We were advised that one person attended a day centre every day. One person told us, "I like to spend time in my bedroom watching my own DVD's and I use my exercise bike".

One person living at the home told us, "The staff are nice and take me horse riding". Relatives we spoke with told us, "Most of the staff are kind". One relative advised: "There are two staff in particular who are excellent and know my relative really well".

Requires improvement

# Is the service responsive?

## Our findings

Each person had a care plan to tell staff about their needs and how any risks should be managed. Many of the care plans we looked at were not dated and it was difficult to confirm that these were up to date. We asked relatives if they were involved in care planning and reviews and their comments included; "No I'm not involved in care plans"; "I've never attended a review meeting".

Plans contained details of the choices which people had made in relation to their lifestyle and details of their needs based on their culture and religion. One person had bed rails fitted to their bed but there was no assessment in place regarding their use.

We looked at the opportunities people had to undertake interesting activities each day. One person told us they did things they enjoyed. On the day of our visit two people were taken out by staff for lunch, however, two people living at home were at risk of social isolation and had no stimulation. During the inspection we noticed that they were not offered the choice of participating in any social activities during the day, and they experienced little contact or contact from staff who had only limited interaction with them. We saw one person was constantly being told to sit down by staff; this was a concern raised also commented on by a relative we spoke with who told us, "Staff keep telling [name of relative] to sit down and they don't want to".

One person told us, "I have asked to go away on a holiday, but there are not enough staff to take me". We asked members of staff if people had been offered the opportunity to have a holiday this year. They told us that some people would love to go on holiday but thought there would be an issue regarding staffing. Relatives we spoke with told us that there used to be activities offered to their relatives, comments included, "There used to be a mini bus to take people out; but this has gone, not so much going on now and holidays never happen"; "[name of relative] is bored here, staff do not understand their needs and do not provide activities that interest them". One relative we spoke with told us, "[name of relative] likes car rides and the use of sensory equipment, Lichfield Road do not offer this".

A relative we spoke with told us, "I like [name of relative] to come and visit me at my home, on one occasion we had to send [name of relative] home because the staff had not put any incontinence aids in their bag, so we were unable to support with personal care needs and they missed quality time with the family".

A relative we spoke with told us, "The staff have told me that [name of relative] needs to move from Lichfield Road, I keep asking the reasons why and no-one can tell me; they have recently lost a placement to another home because staff did not take him to his planned visits to see the home".

Staff told us that a person had been without their wheelchair for six months, we explored this further and were informed that the wheelchair was in bad repair when the person had been admitted to the home. . Whilst the person was able to move around the home with the assistance of a walking aid the wheelchair had been identified as necessary for moving outside the home. During the inspection the newly recruited manager made immediate arrangements for a wheelchair assessment

People told us that they could go to the manager or staff if they wanted to complain about anything. One person told us, "I would tell the staff if I was not happy".

No formal complaints had been recorded in the home's complaint log since our last inspection. Following this inspection the provider informed us that complaints had been received and responded to appropriately but there were no records available to confirm this.

Relatives we spoke with told us, "I don't know the complaints procedure, but I would just approach the staff"; "I have made complaints but nothing is ever done about them". One care staff we spoke with told us they did not know what the complaints procedure was.

The provider did not convey openness to receiving complaints and there was a risk that people and relatives would not know how to make a formal complaint. People who lived at the home had been provided with an easy to read version of the complaints procedure. However this was kept within their care files in the office and was therefore not easily accessible. There was no copy of the complaints procedure on display in the home. In one person's care file there was a copy of a complaint procedure available however it related to a home that they had previously lived in.

Inadequate

# Is the service well-led?

## Our findings

Staff and relatives we spoke with told us they were not involved in developing the service. All the staff we spoke with told us they had not been asked to give their views on the quality of the service delivered. Comments from people's relatives did not evidence that their views on the quality of the service had been sought.

Our inspection did not find that the leadership, management and governance of the home had been effective. The registered provider had not provided the required additional support, resources or monitoring required to ensure the service delivered high quality and person centred care.

The service manager told us they had only been in post for one week. Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC) of important events that happen in the home. Following our visit the service manager confirmed that there was no evidence to suggest that people rights had been protected and no evidence that any authority to apply restrictions on people peoples liberty in line with legislation had been sought. Requirements to notify CQC or incidents and events had not been complied with.

At the time of our inspection the home did not have any senior care support. This meant that apart from the nominated shift leader at any time there was no one in day to day charge of the home. The service manager visited the home briefly on the day of our inspection. They told us that interviews were planned to recruit a team co-ordinator who would be based full-time in the home to offer management support and guidance to the care staff. We found that The registered provider had completed an audit in July 2015 which identified that care staff required support, leadership and guidance; we found this issue remained the same despite an internal action plan being produced.

People's relatives were not complimentary about the management arrangements. A relative we spoke with told us, "Managers never stay here, staff have no support"; "I have no idea who the manager is, they change so much".

Staff told us that the newly recruited manager was approachable. One member of staff told us, "She is very approachable and we are looking forward to some management support here". Another staff member said "We have been without a manager for too long, it is horrible without a manager, we are all exhausted". Some staff we spoke with were unclear about their roles and responsibilities and told us, "Sometimes we are unclear about what to do, we have to deal with all the daily appointments, and we are just on our own".

Although there were some systems in place to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against key risks in relation to inappropriate or unsafe care and support and management of risks. The provider had undertaken an audit in July 2015 to focus on the key question 'Is the service safe?'. We found that some of the issues they had identified remained the same despite an internal action plan being produced. The providers own audit had failed to identify all of the concerns we found during this inspection.

We asked care staff about the procedures for reporting accidents and incidents. They told us that when these occurred they completed a form and usually left this on the manager's desk. A folder was available in the home for incident reporting but we found that there were no records made for 2015.

Staff told us that they reported accidents for people living at the home and for staff working at the home. Records we saw contained some details of the accidents, however, not all reports had the outcome clearly recorded. We asked the provider to send us evidence of how incidents are recorded and monitored and any evidence that accidents, incidents and safeguarding concerns are analysed to identify any patterns or trends. The provider responded that there was currently no systems in place for monitoring and analysing accidents and incidents at Lichfield Road.

There were no evidence that consultation and discussion with people who used the service had been undertaken to seek their views on the quality of the service or about issues that would like to see addressed. The specific record for logging minutes of staff meetings and resident meetings indicated there had been no meetings in 2015. Some staff told us there had been a staff meeting; however, the service manager confirmed there were no records available of the meeting that had been held.

These issues regarding governance of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

Inadequate

# Is the service well-led?

We looked at the systems in place to safeguard people's money. Staff told us that they counted and checked people's monies at every shift changeover to make sure it was correct. We saw staff doing this during our visit.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure that care was provided in a safe way for people who used the service.12(1) The provider had not assessed the risks to the health and safety of people using the service and had subsequently not done all that was possible to mitigate any risks that were known or identified.12(2)(a)(b)<br><br>The provider had not ensured that the staff supporting people had adequate qualifications, skills and experience to do so safely and meet their needs. 12(2)(c)<br><br>The provider had not protected people from the risk of infection through poor management of clinical waste and through inadequate cleaning of some areas of the home. 12(2)(h) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>The provider had failed to ensure that people were treated with dignity and respect and that their rights to privacy were upheld. 10(1)&(2)(a)(b)<br><br>The provider had failed to ensure that people were supported to participate and have access to activities and everyday engagement in the community. 10(2)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider had failed to ensure there was sufficient numbers of suitably skilled and experienced staff to meet people's care needs. Regulation 18(1) |

This section is primarily information for the provider

# Action we have told the provider to take

The provider had not ensured that staff received appropriate support, training and professional development as was needed so that they could carry out the duties to support people in the home.18(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<br><br>The provider's systems for monitoring the quality of the service was ineffective and together with arrangements in place to monitor and manage individual risks failed to ensure the health, safety and welfare of people using the services. Records relating to care and support were not maintained and this omission was not identified by the providers own assurance system. Regulation 17 (1) 17(2)(a)(b)(c)& (e)<br><br>We will publish and report on action we have taken following decision and representation processes. |

**The enforcement action we took:**
We have issued a warning notice to be met by 6 November 2015.