Haversham House Limited

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Inspection report

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Date of inspection visit:
01 June 2016

Date of publication:
20 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 1 June 2016. This was an unannounced inspection. Our last inspection took place in March 2015 November 2015. At that time we found the provider was meeting the required Regulatory requirements.

The service is registered to provide accommodation and personal care for up to 59 people. People who use the service have physical health and/or mental health needs, such as dementia. At the time of our inspection 47 people were using the service. However, one of the people had been admitted to a local hospital after sustaining a serious injury at the home.

The service did not 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 and associated Regulations about how the service is run. A new home manager had been working at the service for approximately two months. However the provider informed us this manager left the service in the 48 hours following our inspection.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into '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.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and

improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely and people were not always protected from the risk of abuse. This meant that's people's safety, health and wellbeing was not consistently promoted.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced.

There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure decisions were made in people's best interests when they were unable to do this for themselves. Some people who could make choices about their care were being restricted unnecessarily and were unable to move around the home freely. Some people were unable to make decisions about their care were being unlawfully deprived of their liberty.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. Prompt referrals to health and social care professionals were not always made in response to changes in people's needs or behaviours. There were gaps in some people's care plans which meant staff didn't always have the information they needed to provide safe and consistent care.

People's dignity and independence was not always promoted and staff didn't always have the time to engage with people in a manner that was meaningful to each individual.

People and their representatives were not always involved in the planning and review of their care. As a result, people didn't always receive care that me their needs or preferences. People were not supported to participate in leisure and social based activities that were meaningful to them.

People were reluctant to complain about their care and effective systems were not in place to manage complaints to improve people's care.

The provider did not always notify us reportable incidents and events as required and the CQC rating from our last inspection was not being displayed in accordance with the law.

People were supported to eat and drink in accordance with their preferences. However, mealtimes were chaotic and disorganised which impacted on people's dining experiences.

Safe recruitments systems were in place to ensure staff were suitable to work at the home. People spoke fondly about the staff and at times, we observed some positive interactions between staff and people.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Medicines were not always managed safely and there were not always enough staff to keep people safe and meet peoples care needs and preferences.

People were not consistently protected from the risk of abuse.

Is the service effective?

Inadequate

The service was not effective. The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were always made in people's best interests.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being followed and people who were being deprived of their liberty were being deprived lawfully

Staff did not always have the knowledge and skills needed to meet people's needs effectively. Prompt referrals to health care professionals were not always made when people's needs changed.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always supported to receive care and support in a dignified manner.

Staff knew people well, but didn't always have the time to engage with people in a manner that was meaningful to each individual.

People were involved in making some choices about their care.

Is the service responsive?

Inadequate

The service was not responsive. People and their representatives were not always involved in the planning and review of their care. People did not always receive care that met their care needs and

preferences.

People were reluctant to complain about their care and complaints were not always managed effectively.

Is the service well-led?

Inadequate

The service was not well led. There was no registered manager working at the home.

Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm from occurring.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

The provider did not always notify us of reportable incidents and events that occurred at the service. The provider was not displaying the CQC rating of the home as required.

Haversham House Limited

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 1 June 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We also met with representatives from the local authority to discuss the concerns they had with quality and safety at this service.

We spoke with 10 people who used the service and three people who visited the service. We also spoke with, five members of care staff, the newly appointed home manager, the operations manager and a manager from another local service owned by the provider. We did this to check that good standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of 14 people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, staff rotas and training records.

Following our inspection we shared our concerns with the local authority. We did this because we had significant concerns about people's health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

Some people told they did not feel safe at Haversham House because of the behaviours some people displayed. One person said, "People (people who used the service) come into my room at night, it really unnerves me". We found that risks to people's safety as a result of people's behaviours were not always assessed and planned for. For example, two people who used the service frequently displayed episodes of aggression towards other people who used the service and staff. The risks associated with these behaviours had not been assessed or planned for as no risk assessments or care plans were contained in their care records. Staff told us they managed these people's behaviours that challenged by calming them down and offering them cups of tea. However, this appeared ineffective as care records showed these incidents could remain on-going for periods of up to an hour. This showed the provider had not always assessed and planned for the risks associated with people's behaviours that challenged.

We found that effective and prompt action was not taken to identify and manage people's risk of falling. One person told us, "I fall a lot". Care records showed there had been at least 23 unwitnessed falls in April and May 2016. We saw that one person's increased risk of falling due to change in their health had not been identified, assessed or managed. This person fell and sustained a serious injury, which meant they could not be assured that their fall was unavoidable. Another person's records showed that a referral to a health care professional was only made after they had fallen on five occasions in a one month period. This showed there was a delay in seeking professional advice regarding people's risk of falling. Assessments of people's safety when using the stairs were not always completed to ensure they were safe to use the stairs. We observed two people coming down the stairs in an unsafe and unsteady manner. The risks associated with using the stairs unsupervised had not been assessed or planned for as no risk assessments or care plans were contained in either person's care records relating to this. This meant people could not be assured that the provider was effectively managing their risk of falling.

Where risks to people's safety had been recognised and planned for, we found that care was not always delivered in accordance with their agreed care plan. For example, five people required regular repositioning to prevent skin damage. Records showed and staff confirmed this did not happen as often as planned. One staff member said, "Nine times out of ten repositioning can be out of sync". This meant people could not be assured that their risk of skin damage was being managed effectively.

People told us they didn't always get their medicines when they needed them. One person told us how their prescribed pain relief was regularly given 45 minutes later than planned which meant their pain was not adequately controlled. This person said, "They have let this slip, but I am trying to get it back to the earlier time". Another person said, "They've slipped up this morning. I got my medicines and breakfast late". We saw and staff confirmed that effective systems were not in place to ensure medicines were administered as prescribed. We saw one person receive their morning medicine three and a half hours late. This person then received a second dose of this medicine at approximately before they should have done without allowing the prescribed time gap between doses to pass. This person's MAR did not show they had received their morning medicine late. This meant the staff who administered the second dose of this medicine had no way of knowing they were administering it too soon. We intervened to stop a second person from receiving their

prescribed medicines at the wrong time.

Effective systems were not in place to ensure people's medicines were readily available. One person told us and their medicine administration records (MAR) showed that some of their prescribed medicines had been out of stock for five days. One of these medicines was available through the use of the service's 'homely remedies' stock (homely remedies are medicines that are available over the counter to help manage mild or short term illness or discomfort). However, the other medicine was not administered as it was not available. This meant the person was unable to receive their medicine as prescribed. Staff told they had ordered this medicine once they realised it was out of stock, but an effective system was not in place to ensure people's prescribed medicines were available at all times.

We found gaps in the temperature monitoring of the fridge that was used to store people's refrigerated medicines. There were 11 days in May 2016 where the temperature of the medicines fridge had not been recorded. One of these gaps lasted for four consecutive days which meant people could not be assured that their refrigerated medicines had been stored safely and in line with medicines manufacturers' guidance during that period of time.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a consistently safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to identify, record and report abuse to the managers. However, we found that effective action was not taken by the managers or provider to protect people from the risk of abuse. Suspected abuse was not always discussed with or reported to the local authorities safeguarding team in accordance with local and national guidance. For example, the care records of two people showed that 11 incidents of suspected abuse had not been reported to the local authority as required. This meant people were not protected from the risk of ongoing incidents of suspected abuse.

We found that plans to protect people from abuse were not followed to promote people's safety. For example, one person's care plan stated they needed staff to 'document their whereabouts every 30 minutes to ensure they were safe'. Their care record showed these checks were not always completed as planned. When we checked their observation sheet at 1:12pm, it had not been updated since 11:30am. This showed their whereabouts had not been documented as planned for over 90 minutes.

The above evidence shows that people were not consistently protected from the risk of abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the staff were not always available to meet their care needs and preferences, and the staff we spoke with confirmed this. One person said, "They haven't got enough staff to do what people want". A visitor told us, "[Person who used the service] has to wait a long time for things to be done. The staff are doing the best they can, but there's not enough of them". All the staff we spoke with confirmed people's needs were not always met in a timely manner. One staff member told us people were not assisted to change their position every two hours as planned because, "We don't have enough staff". Another staff member told us people were unable to move freely around the home as staff were not always available to keep them safe when they moved into areas where they posed risks to other people.

Our observations showed staff were not always available to keep people safe and support people in a timely manner. When we arrived at the service at 8.30am we could hear people's call bells ringing. We saw that one

person's call bell rang over a 20 minute period before they received the support they requested. When their call bell had been ringing for 20 minutes, we heard the deputy manager tell a senior, "You need to go and check on those rooms, they have been ringing for a while". This showed people didn't always get the support they needed when they needed it.

Staff told us there should always be a staff member present in communal areas to ensure people's safety. However, we saw multiple occasions where no staff were present in these areas. For example, on the unit for people who lived with dementia, staff were not visible in the lounge on multiple occasions. On one of these occasions we observed two people that became agitated and were raising their voices to each other. No staff were present to immediately diffuse the situation which meant people were at risk of harm to their safety and wellbeing. In another lounge, we had to intervene as a person who was at high risk of falling had stood from their chair. This had triggered their chair alarm to ring, but no staff were visible in the lounge area to respond to the alarm which meant the person was at risk of falling. When a staff member did come into this lounge after this incident they said, "Where's all the staff". This showed that staff were not effectively deployed to promote people's safety.

The above evidence shows that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe around the staff. Comments included, "The staff are really nice" and, "The staff are very good, I can't fault them". We saw that effective systems were in place to ensure staff employed by the service were of suitable character to work with people who used the service.

Inadequate

Is the service effective?

Our findings

We saw that when people had the ability to consent to their care and treatment, the staff sought their consent before providing care and support. However, we found that when people were unable to make important decisions about their health and wellbeing, the provider did not act in accordance with the law. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. A relative told us their relation had recently changed bedroom due to some of the behaviours they were displaying. They told us that neither they nor their relation had been consulted with about this change and this change had resulted in their relation becoming increasingly disorientated. They said, "We were not consulted to see if there was a better solution". The person's care records showed and staff confirmed that a best interest decision had not been made to support that it was in the person's best interests to move bedrooms.

Some people told us and we saw that people were restricted from moving freely around the home. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

One person told us that although she had a key to their bedroom, they were unable to access their room when they wanted because they had not been given the code to enable them to get through the locked door that took them to the corridor where their bedroom was located. The operations manager told us there was no reason why this person could not be given the code to the door as they had the ability to make decisions about their care. This meant unnecessary restrictions had been placed on this person.

We observed three people attempt to leave the locked unit for people who lived with dementia on multiple occasions. Two of these people verbally stated they wanted to leave the unit. One said, "I want to go home, I've been here long enough now". The other person said, "I want to go home. Once I go through that door, I'm not coming back in". Staff told us they prevented these three people from leaving because of risks to their health, safety and wellbeing and they confirmed these people did not have the ability to make the decision to reside at Haversham House. No applications had been made to ensure these three people were being lawfully deprived of their liberty as no Deprivation of Liberty safeguards (DoLS) request had been made. This meant the requirements of the Mental Capacity Act 2005 and the DoLS were not being met and people could not be assured they were being restricted in their best interests.

The above evidence shows people were being restricted unnecessarily or unlawfully. Decisions about people's care were not always made in accordance with the requirements of the MCA when they were unable to make these decisions for themselves. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received training. However, the concerns we identified with the way people received their care and staff records showed there were significant gaps in the staffs' knowledge and skills. For example, we saw the requirements of the MCA were not being consistently followed by the staff as the staffs' understanding of the Act was poor. Training records showed only two percent of the staff had completed training in MCA and DoLS, and suitable plans were not in place to promptly address this knowledge gap. Care records showed people's behaviours that challenged were not always being managed effectively. For example, one person's care records showed their behaviours escalated into aggression towards staff during the night when staff told them to return to bed. Records did not show that staff managed this person's behaviours by trying to identify why the person was restless at night to address the reason for their behaviour. Some staff told us they had received training in dementia awareness, but none had received training specifically on managing behaviours that challenged. This meant staff did not have the knowledge and skills required to manage people's behaviours that challenged.

Most people told us they were able to dine and drink in accordance with their individual preferences. For example, one person told us, "I sometimes like ready meals. I only have to ask and they get them in for me". Another person told us, "The food is great". We also saw that people's diet and fluid intake was monitored if required and changes in people's weight was acted upon as required. However, we saw that mealtimes were chaotic and unorganised. For example, two staff were initially available to support people on the unit for people who lived with dementia at lunch time, but one staff member had to leave on a number of occasions to collect items, such as cutlery which left one staff member alone. This resulted in one person who was being supported to eat being left in the middle of receiving this assistance as the remaining staff member had to move away to support another person who was displaying behaviours that challenged. This meant their mealtime experience was interrupted. At the start of lunch in the main dining room only one staff member was present. They asked an inspector for assistance as they also needed to collect cutlery for people. This showed that staff were not effectively deployed to ensure people had a pleasant and effective dining experience.

The above evidence shows that staff were not always effectively deployed or suitably skilled to meet people's individual needs. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that prompt referrals to health and social care professionals were not always made in response to peoples' changing needs. For example, one person who had attempted to assault or had assaulted other people on at least three occasions between March and April 2016 had not been referred to a doctor or a community mental health nurse for an assessment of their behaviours that challenged in response to these incidents. A care plan to address some of these behaviours had been devised by staff in May 2016 without any input from relevant health care professionals. Another person had fallen five times in April 2016 before they were referred to a health care professional for assessment and advice. This showed people were not always supported to access prompt assessment and advice from health care professionals in response to changes in their health and wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Some people told us and we saw that their right to independence was not consistently promoted. One person and their visitor told us staff often didn't enable them to maintain or regain independent living skills. For example, they said, "Agency staff try and put me into a wheelchair when I can walk". They also told us night staff woke them up to go to the toilet when they were able to identify and alert staff if they needed assistance with accessing the toilet. Day staff confirmed this person could decide when they required the toilet. We observed staff assisting one person to eat when their care plan stated they could eat independently with specialist equipment. We saw the equipment was in place, but staff immediately assisted them to eat their lunch, rather than prompting or encouraging them to do this independently as planned. We later observed this person eat their dessert independently which showed they had the skills to eat independently.

We saw staff administer creams to two people in communal areas. One person's skirt and blanket was lifted up to enable the staff member to apply cream to their knees. The second person had cream applied to their shoulder at the dining table. Other people were present in these communal areas on both of these occasions. This showed that people's privacy and dignity were not consistently promoted.

The above evidence shows that people's right to be treated with dignity, privacy and respect was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us and we saw that the staff knew them well. For example, one person told us that staff new how they liked to be positioned in their chair. Another person told us staff knew how to make their cup of tea and that staff did this, "Just right". However, people told us staff didn't always have the time to sustain meaningful conversations with them. One person said, "I don't get to talk to the staff much, but I can talk to the other people who live here". Another person said, "They are always rushed, so don't have the time to spend with us". Staff also confirmed that they didn't always get to spend quality time talking with people. Comments included, "I don't get to give my time to residents, particularly in the large lounge. It's not fair on them" and, "We got the last resident up at 12pm today. We don't have time to chat lots, it would be nice if we did". This shows that although staff knew people well, they didn't always have the time to engage with people in a manner that was meaningful to each person.

Most people told us they were very happy with the way the staff cared for them. Comments included, "The staff treat me well" and, "I think this place is first class". We saw some positive interactions between people and staff. For example, we saw one staff member compliment a person by saying, "You're looking lovely today". The person responded by smiling and saying, "Thank you". We also saw another person tell a staff member, "I love you" and the staff member responded by saying, "I love you too". Again, this made the person smile.

Most people told us and we saw that they were given choices about some parts of their day to day care. For example, people told us they could choose their drinks, meals and clothing. We saw that where people

could make choices about their care, staff respected the choices people made. For example, we saw a member of staff respect one person's choice to change their mind about what they wanted to eat. This person declined to eat the meal they had initially selected, so staff asked them what alternative meal they would like. When the person made this choice, the staff member organised an alternative meal to be prepared. Staff told us how they supported people who had communication difficulties to make choices about their care. For example, a staff member told us how they supported a person was very hard of hearing to choose what they wanted to wear. They said, "I show them their clothes and get them to choose". This showed staff considered and adapted to people's communication styles when supported them to make choices about their care.

Inadequate

Is the service responsive?

Our findings

People told us they were not involved in the planning or review of their care and people's relatives confirmed this. For example, one person told us how there care plan had been devised without their involvement. They said, "They [the staff] have put me down to be woken up, turned and taken to the toilet in the night. I have said I can decide that for myself, I don't need that help". They told us that night staff regularly woke them in the night to do these tasks which resulted in disturbed sleep. Staff we spoke with confirmed this person could decide when they wanted to go the toilet without being prompted. Despite telling the staff they did not need this support, no changes had been made to their care plan to ensure it was planned around this person's individual needs and preferences. A relative told us, "We never get asked to input into the planning of [person who used the service's] care". This relative gave us an example of how a recent change had been enforced on their relation without their or their relations input. They told us and we saw that this change had had a negative impact on the person's wellbeing. This showed people and where appropriate, their relatives were not always involved in the planning and review of care. This meant people did not always receive care that was responsive to their individual needs and preferences.

Because of the lack of involvement of people and their relatives in the care planning process, care records did not always contain the level of detail required to inform staff about how people wished to receive their care and support. For example, some people couldn't always verbally tell staff how they wanted to receive their care because of their health conditions. Care plans did not always detail how people liked to receive their personal care, such as what clothes and accessories they liked to wear and what toiletries they liked to use. Although staff who permanently worked at the service knew people's preferences well because they had been working with people for long periods of time, temporary agency staff did not have this knowledge. This meant there was a risk that people would receive inconsistent care that didn't meet their care preferences, because people's care preferences were not recorded in their care records.

We saw significant gaps in people's care planning which caused people to receive inconsistent and inappropriate care. For example, plans were not in place to guide staff on how to manage people's requests to leave the home. We observed two staff members support a person who repeatedly asked to leave in two different ways. One staff member responded to this person's requests to leave by saying, "You've got to stay here for a bit". When the person responded by saying, "Why?", the staff member answered, "Because you've got to sweetie". The person did not respond positively to this as they immediately returned to the door and tried to leave. However, on another occasion, we saw another staff member respond this person's request to leave by telling them this was their home now. The person responded more positively to this as they then followed the staff member into the lounge where they sat for a short while. This showed two different approaches were used by the two staff members which had two different outcomes for the person. Staff confirmed they hadn't been formally told how to manage this specific behaviour for this person, so they were doing the best they could without access to the required guidance.

People told us and we saw that they were not consistently supported to engage in social and leisure based activities that were meaningful to them. One person said, "I had lots of hobbies before I came here" and, "They've appointed an activities worker, but we've not done much". Another person said, "I'd like to have a

game of cards or dominoes, but no one here likes to play". Relatives confirmed that people's leisure and social needs were not met. For example, one relative said, "There's no stimulation. They used to have access to a bus to take people out, but that stopped about six months ago". We saw that people who resided on the unit for people who lived with dementia were not supported to engage in meaningful activities to help manage their behaviours that challenged. On this unit, a Mary Poppins DVD played all day during our inspection and people who were able to, spent time moving around the unit with the purpose of trying to exit the unit and open doors. This showed people were not supported to engage in activities that met their individual needs or preferences.

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

There was a complaints policy in place. However, some people told us they did not feel empowered to complain about their care. One person said, "I could raise my concerns, but I feel I wouldn't be listened to". Another person said, "I wouldn't want to bother them". This showed people were reluctant to complain about their care. Relatives told us they felt able to complain about the care. One relative told us about a formal complaint their family had made to the provider. However, they had not received an update about the outcome of this complaint and when we checked, there was no record of this complaint in the complaints records at the home. This showed that effective systems were not in place to ensure complaints were recorded, investigated and managed effectively to improve people's care.

Inadequate

Is the service well-led?

Our findings

There was no registered manager, but a new home manager had been working at the home for approximately two months. Following our inspection, the provider informed us the newly appointed manager had left the service. Alternative management cover had been arranged, but this showed there was a lack of management consistency and stability at the home.

Safety incidents at the home were not being effectively analysed to identify and respond to emerging patterns and themes. For example, incident records showed there had been 23 unwitnessed falls in April/May 2016. This showed that on 23 occasions staff were not available to respond to people's risks of falling. This had not triggered a review of staffing levels or staff deployment to help manage peoples' risk of falling. The operations manager told us a review of staffing based on peoples' dependency levels had not been completed since November 2015. This meant we could not be assured that there were enough staff available to keep people safe.

Safety incidents were not always appropriately investigated or responded to, to prevent further incidents from occurring. Lessons were not learnt in response to incidents. For example, when managers identified staff should have sought medical advice following one person's fall where they sustained a knock to their head, no protocol was put in place to ensure staff had clear guidance to follow in the event of another person falling. This showed that lessons were not always learned from incidents to improve people's safety and wellbeing.

Prior to our inspection, the local authority told us they had recently visited the home and had given feedback to the manager about the concerns they had identified. We found that some of these concerns had not been acted upon in a timely manner. For example, the local authority told us they had shared concerns about the risks posed by a person's behaviours that challenged, but we saw that no action had been taken to assess or plan for the risks associated with this person's behaviours. This showed the management team had not been responsive to concerns about people's safety and wellbeing.

The information contained in people's care records was not being effectively monitored or analysed by the managers to ensure people's needs were being managed effectively. For example, the management team had not identified that plans were not in place to help staff manage people's behaviours that challenged. The management team had also not identified that people were not always receiving their planned care. For example, people were not always supported to change their position as often as planned to promote their safety and wellbeing. This showed that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and improved.

We asked for evidence to show how the provider monitored quality at the service. The operations manager told a quality audit had been completed, but there was no record of this available for us to view as it was stored on the computer of a staff member who was on leave. This meant that the management team could not access the audit to start to address any concerns it had identified.

Significant training gaps were not being promptly addressed. For example training records showed only two percent of staff had received training in the Mental Capacity Act 2005. Staff we spoke with showed a poor understanding of the Act and the training plan in place did not address this gap. This showed action was not being taken to improve staffs' knowledge of the Act, to improve people's care experiences.

Management records showed that feedback from people about their care had not been sought since August 2015. This meant people's views about their care were not being considered to enable improvements to the quality of care to be made.

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

We could not be assured that the provider understood the responsibilities of their registration with us. The provider had failed to notify us of at least 11 incidents of alleged abuse and seven DoLS authorisations as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

On 1 April 2015, it became a legal requirement for provider's to display their CQC ratings for their registered locations. We found that the rating from our last inspection of Haversham House Limited was not being displayed as required. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.