Lifeways Rose Care and Support Limited

Rose Meadow

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**

Summary of findings

Overall summary

We undertook an inspection of Rose Meadow on 12 and 17 December 2018. The inspection was unannounced. Rose Meadow has been registered since October 2011. The service provides accommodation, personal care and support for up to ten people in Misterton, North Nottinghamshire. At the time of our inspection, seven people were using the service. The service is focused on supporting people with a diagnosis of a learning disability.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Since October 2015, government policy has aimed to develop care services in line with values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Rose Meadow was registered with the Care Quality Commission before the 'registering the right support policy. Rose Meadow does not currently fit within best practice models for 'registering the right support'

At the last inspection, on 4 February 2016, we rated the service as 'Good'. During this inspection we found concerns about the safety of the service. This included breaches of regulations 11, 12, 17 and 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. This is the first time the service has been rated as 'Inadequate'.

At the time of our inspection there was no registered manager in place, however a newly recruited manager was in the process of registering. A registered manager is a person who has been registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are "registered persons." Registered persons have the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

There was no clear strategy and governance to ensure good outcomes for people. The registered manager had left in February 2018. A provider audit was completed seven months later, and had highlighted concerns about the service. Despite an action plan with the Local Authority we saw minimal evidence of change in the service. We were concerned that there were multiple areas of unsafe care, and the provider had failed to address these issues promptly and effectively.

During this inspection we found the service was not safe. Care plans did not guide staff on how to respond to people's needs. Records showed us that staff responses were varied, ineffective and at times harmful to people's wellbeing. Incidents had not been appropriately referred to the Local Authority when safeguarding criteria had been met.

The risk of fire and legionella disease had not been assessed and managed appropriately. This put people at risk of living in an unsafe environment. The home was unclean. Medicines were not stored and recorded appropriately. This put people at risk of medicines not being managed effectively.

Staff were not deployed effectively around the home to ensure people's needs were met. People's one to one care support needs were not clearly assessed and people were sometimes left alone.

People's diverse needs were not recorded accurately or recognised by staff. Short-term activities were provided and we saw people enjoy these. Longer term goals required embedding in the service.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support positive practice. Formal complaints were responded to and a new accessible complaints procedure had been created to encourage people's voice. Further work was required to ensure people were involved with care planning

Staff did not work effectively with other organisations and professional guidance had not been effectively recorded to guide staff. Staff were not sufficiently trained. Safeguarding and mental capacity training had expired, staff had limited knowledge in these areas and care had not followed evidence based guidelines.

People were supported to maintain a balanced diet. People appeared to enjoy the meals given to them, we saw people were included in meal time decisions.

Staff were caring in their approach and treated people with kindness and dignity. However, a lack of guidance meant a non-caring approach to challenging incidents. Staff expressed a desire to learn more about responding to incidents but this had not been addressed.

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.

Following the inspection, we received an action plan from the provider. We also received some evidence that some concerns had been resolved. The provider has agreed to continue sending us action plans and an

analysis of their progress. We intend to inspect this service again to ensure these improvements are embedded in the service. We remain concerned that these issues were not resolved prior to our inspection visit.

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.

Care plans did not guide staff on how to respond to people's needs. Staff responses to people's needs were varied, ineffective and harmful to people.

The risk of fire safety had not been assessed and managed appropriately.

Staff were not deployed effectively around the home to ensure people's needs were met

Medicines were not managed safely. This put people at risk of not getting medicines as prescribed.

The home was unclean and people were at risk of infection

Lessons had not been learnt when things went wrong

Is the service effective?

Requires Improvement

Mental capacity assessments were not of sufficient quality. Those who were assessed as lacking capacity, had no best interest decision in place to support staff. People were restricted in their routines.

Care was not delivered in line with evidence based guidelines

Staff were not sufficiently trained

People were supported to maintain a balanced diet

Staff did not work effectively with other organisations

There premises were adapted for the people living at the service

Is the service caring?

Requires Improvement

Staff were caring in their approach, however a lack of guidance

meant non-caring approach to incidents.

People were treated with kindness and compassion throughout the day

People were treated with dignity and respect

Is the service responsive?

Requires Improvement

People's diverse needs were not recorded accurately or recognised by staff.

People's short-term activities were provided, longer term goals required embedding in the service.

Formal complaints were responded to. A new accessible complaints procedure had been put into the service to support people's voice

Is the service well-led?

Inadequate

There was no clear strategy and governance to ensure good outcomes for people

People have not been adequately engaged with in the service

The service has not shown evidence of learning, or improvement.

The service does not effectively work with other services, to ensure positive outcomes

Rose Meadow

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 comprehensive inspection took place on 12 and 17 December 2018 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection visit took place, we gathered information known about the service. We considered notifications the provider had sent to us. A notification is information about important events which the provider is required to send us by law. We also considered any information received from the public and professionals.

Before the inspection we requested the provider submits a Provider Information Return (PIR). The PIR asks the provider to give key information about their service, how they are meeting the five questions and what improvements they plan to make. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we carried out general observations of care and support and looked at the interactions between staff and people who used the service. We spoke with three people who used the service, four care staff and the manager. We looked at the relevant parts of the care records of five people who used the service. We also looked at three staff recruitment files and other records relating to the management of the home. These included audits, policies and incident records.

The inspection found some concerns. After the inspection, we requested the provider sent us an action plan detailing how they plan to resolve these issues. We have considered this action plan when writing this report.

Inadequate

Is the service safe?

Our findings

Systems and processes were not in place to keep people safe from behaviour that challenged others. The care plans were of poor quality and did not guide staff on how to effectively respond to behaviour that challenged others. For example, one care plan stated that when a person became upset they should be encouraged to go to their room to calm down. We saw damage to the walls and furniture in their room, and incident records showed this person did not always calm down in their room. Staff told us that when this person goes to their room, they self-harmed by hitting walls and furniture. We were concerned that despite this method being ineffective, staff had continued to use it and it had put the person at risk. Additionally, where the person had caused substantial damage to a wall, there was no evidence that potential injuries had been considered.

As care plans did not provide guidance, we saw that staff had responded in variable and inappropriate ways to behaviour that challenged. A staff member told us, "We have been pretty much left to our own devices." Staff had completed 'incident forms'. These records showed that inappropriate staff responses included punitive actions like restricting access to outside spaces, and phoning family for advice. These inappropriate staff responses could be harmful to people's wellbeing.

There was no evidence that a regular review of these incidents had been completed. So, actions were not put in place to prevent re-occurrence or challenge inappropriate staff responses. This meant repeated incidents had re-occurred that put people at risk of harm from themselves and others at the service. For example, one person had verbally threatened to harm other people five times in June and three times in July. This had escalated to a physical assault on another person. This risk had not been identified and there was no plan in place to prevent this occurrence. Because this was not recognised, there had been no referral to the Local Authority to assess the risk of harm. The Care Quality Commission has also not been notified, the provider is required to do this by law so we can assess the safety of the service.

Care plans and risk assessments were of poor quality and had contradictory information. This put people at risk of physical and mental health needs not being met safely or consistently. For example, one person had a history of seizures. One care plan stated that staff should remain with the person in the bathroom, while another care plan stated they should be left alone for privacy. Staff told us that they do not remain with the person. The failure to adequately assess this person's risk, put them at risk of harm when bathing.

Staff did not always follow care plans that were in place. For example, a care plan explained that a person struggled to manage money. The care plan explained how staff should support this person to maintain their independence in a safe way. We saw an 'incident form' where staff did not follow this plan. By not following the agreed plan, this caused the person anxiety. This resulted in threats to staff and the person punching furniture. There was no evidence that this incident had been learnt from to keep the person and those around them safe.

People had not been protected from the risk of fire for an extended period. The weekly environment check had identified that the fire doors were not working in October 2017 and were still not working in December

2018. The manager could not provide evidence that the doors were now working. The weekly emergency lighting test had not been completed for the previous eight months. Records showed an annual site review found these lights were broken in October 2018. There was no evidence that they had been repaired. People had personal emergency evacuation plans in place. These are to guide staff on how to support people in the event of a fire. The fire drills that had occurred had shown two service users had repeatedly refused to leave. The evacuation plans did not recognise this risk and no alternative plans had been made. This placed people at risk of harm.

Staff were not deployed effectively around the home to ensure people remained safe. The Local Authority had identified that people required one to one staffing support to have their needs safely met. We found the number of hours and purpose of this support was not clearly detailed in people's care plans. For example, one person had been recently reviewed and allocated 11 hours of one to one support. Their care plan stated "1:2 during the day time 7:30-9:30 and has 4 hours 1:1." This was contradictory and no further information was provided to guide staff. Staff who were arranged to remain with this person for one to one support in the afternoon, were not always in the same room as the person. This could put the person at risk.

Medicines were not managed safely. People who were prescribed 'as needed' medicines did not have a clear protocol in place to ensure staff knew when to give them effectively. These medicines were given regularly, and with no reason recorded for why it was needed. For example, one person required 'as needed' medicine for bowel movements up to two times a day when needed. This had been given twice daily for 7 days. There was no recording as to why this medicine was given, and whether their bowel movements had been considered when administering this medicine. Some stored medicines were out of date, we could not be assured that these were no longer given to people. We found medicines were in the care home but not on people's medication records. This meant medicines may not be given to people as prescribed. We found that medicine had gone missing from a future blister pack. The manager was unaware of where this had gone. They later identified that the person had taken it by mistake. There was no evidence in the person's care records that this was a risk. This meant people were not protected from the risks associated with medicines.

The home was unclean, which put people at risk of the spread of infection. Areas of the home required renovation to ensure future cleaning would be effective. For example, handles in communal areas were visibly dirty and surfaces were peeling. These exposed surfaces could allow bacterial growth. People's mugs were badly stained and dirty. There were cleaning schedules in place, but these proved ineffective at ensuring a clean environment. One person's bedroom cleaning schedule noted them as independent. Their living area was unclean and unhygienic. The person had been assessed as unable to make decisions for themselves in other areas and needed support with other daily routines. There was no evidence that this had been recognised or their ability to clean for themselves adequately assessed.

People were not protected from potential Legionnaires Disease. Legionella is a type of bacteria found in water systems and can put people at risk of seriously ill health. We expect care homes to have a way of managing this risk. The care home had a site risk assessment for Legionella Disease. This required weekly flushing of infrequently used water sources. Records showed us that weekly flushing had only occurred seven times in 2017 and 15 times in 2018. The outside tap was not included in this, and there was no evidence it had been flushed. The lack of frequent flushing can allow stagnant water to build up in the system and put people at risk of Legionella Disease. This risk was increased by limescale over taps and shower heads. These had not been cleaned and replaced as per the site risk assessment. Since the inspection, the provider has advised that a water test was completed and the sample did not present a risk of Legionella. They have assured us that systems are now in place to ensure the effective management of Legionella Risk. We shall assess this at the next inspection.

At this inspection we found multiple concerns of people's safety being put at risk. These were long standing and an ineffective oversight had meant lessons had not been learnt when things went wrong. For example, staff had recognised the broken fire doors for over a year and action had not been taken to resolve this. Incident forms had no regular review and we identified two people who required referrals to the Local Authority for further safeguarding investigation. Where a regional managers audit had occurred, it had recognised the risks of the service but action had not been taken to resolve this.

The poor management of incidents, insufficient care planning, poor medicine management, and poor environmental control represents a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment was managed safely and pre-employment checks were completed as required. This meant appropriate people were employed to work at the service.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We found that people were being restricted without an assessment of their capacity. The capacity assessments that were in place were poor quality and not appropriate to people's needs. Six of the seven people who lived at the home had capacity assessments which identified that they lacked the capacity to make decisions. However, there was no corresponding best interest decision documentation to advise how staff should support them appropriately. This meant staff were not guided on what support should be given in the person's best interests.

One person had been diagnosed with a health condition. This condition required careful management of food to ensure their well-being. Staff felt that this person could understand their health condition and make choices about what to eat. However, staff told us that their choices could be unhealthy so they had prevented them buying their favourite food. The Mental Capacity Act states a person has a right to make an unwise choice. The staff control had resulted in increased aggression towards staff and other people at the service. Additionally, the food choices that staff had chosen instead, were inappropriate and presented a high risk to this person's health condition. Staff advised that they had not had training on this person's health condition to know what food was appropriate. A staff member said, "We do control what [person] eats. We are trying to act in their best interests. But we have got no capacity assessment to support us." We asked staff if they should be restricting food if the person could make choices, the staff responded, "we probably shouldn't." We found the control over this person's diet to be long standing, without clinical basis and to affect their wellbeing.

The poor quality of mental capacity assessments and lack of best interest assessments was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is through procedures called the Deprivation of Liberty Safeguards (DoLS). We found DoLS had been applied for as required and where conditions were in place these were complied with.

Staff were not sufficiently trained to deliver effective care and support. This resulted in unsafe care practices. Staff told us that they would like further training. Out of 19 staff, six had expired mental capacity training, for three staff this was nearly a year out of date. The staff we spoke with had minimal knowledge on mental capacity and we found restrictive care practices in place. We found that out of 19 staff, seven had expired Safeguarding training. We found staff lacked knowledge on safeguarding and incidents of potential harm had not been appropriately referred to the Local Authority for safeguarding investigation. Out of 19 staff, 16 had expired positive behavioural support training. We had concerns about the inappropriate staff responses

to behaviour that challenged others.

The insufficient staff training is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples needs were not assessed in line with legislation and evidence based outcomes. We saw that people had significant health diagnoses which were not mentioned in their care plan. This meant staff were not provided with guidance on how to support their needs effectively. For example, some people required cream application for skin conditions. There was no guidance on why the cream was needed, what was the person's usual skin presentation and when a referral for medical advice would be needed. This cream had been given regularly without documented reason. There is a risk that due to a lack of evidence based guidance, people would not receive effective care.

Staff did not work effectively with different organisations to provide effective support. Care plans included a 'hospital passport', this was intended to allow staff to pass over essential care information to hospital staff in the event of a hospital admission. We found the information on the hospital passport was incorrect. For example, one hospital passport noted that the person required support to go to the toilet. However, this was not in the person's care plan and staff advised it to be incorrect. The incorrect information could put the person at risk of receiving incorrect treatment in another care or health setting.

People had access to health and social care professionals. However, advice given from these professionals was not clearly documented. This could limit the effectiveness of professional guidance. For example, one person required the use of equipment for their medical condition. They were advised to use this for four hours at a time. Medical advice was not clearly documented on their health condition, why this equipment was used, how to encourage usage, the impact of non-usage and when a review would be needed. Care plans recorded that this person was reluctant to use this equipment, but there was no evidence that this had been fully assessed and a plan put in place for staff to follow.

People were supported to maintain a balanced diet. A person told us, "They [staff] ask what our favourite food is then we go with staff to buy it. If we don't want it we have something else." We saw people enjoying the food they were eating. Staff noticed from non-verbal signs that a person was not enjoying their food. An alternative option was quickly provided to the person.

The home was adapted to meet people's needs. There was a clear layout of the home, and people were seen to navigate the home and communal areas with ease. We saw that efforts had been made to make communal areas safe for people to enter. For example, knives had been removed from the kitchen and locked away. This meant people could enter the kitchen without staff support.

Requires Improvement

Is the service caring?

Our findings

Staff were caring to people in everyday interactions. However, records showed less caring responses to behaviour that challenged others. Staff had a good knowledge on how to recognise when people were becoming distressed and gave clear descriptions about what presentation they look out for. However, staff expressed frustration at the lack of guidance on how to respond to escalating behaviour. During the inspection we saw staff recognised when people would become upset and respond quickly to offer their support. A person told us, "[Staff] ask your feelings and help if (you are) sad." We saw one person would scratch their chin if they were starting to become agitated. Staff were quick to respond to this action, and offered emotional support. However incident records showed that if anxiety was not reduced with a generic response then it would escalate. This resulted in staff responding inappropriately and in a non-caring way to incidents (for example deciding punishments for behaviour). While staff were well intentioned and keen to improve their skills, a lack of guidance and training meant responses to challenging incidents were unskilled and uncaring.

Records showed people had previously had little involvement with their care planning. However, since the new manager commenced their role there was evidence that this had improved. People were beginning to be given options on home décor. A person told us, "I decorated my room how I want it. Purple is favourite colour so I picked purple." People had been involved with resident's meetings, and one person was responsible for recording the notes of this meeting. People at the service were empowered to take up specialist roles as appropriate, for example being involved with interviewing potential staff. Due to people's involvement being more recent, further improvement was needed to embed their involvement fully into the service. Further work was particularly required to involve people with planning their daily routines.

Staff and people at the service had a positive relationship. The three people we spoke with told us that staff were kind and caring. Those unable to talk to us were witnessed having positive interactions with staff. During the inspection, we saw staff encouraged people to become involved with activities that interested them. A person told us, "We do activities and I have decorated the walls." They showed us decorations that they had stuck on the wall and spoke positively about the experience with staff. Another person said, "Staff go to the pub with me, I like them coming. They comfort me." There was a positive relationship seen between people and staff. People were seen dancing happily with staff to songs in the communal area. One person expressed that they wanted their face painted, the staff member completed this in a caring way and asked them to point to parts of their face they wanted painting. It was clear from the interaction that the person enjoyed this activity.

Some people using the service were unable to communicate clearly. It was clear from watching interactions that staff had spent time getting to know those people's non-verbal signs. They recognised these non-verbal signs and responded in an empathetic and supportive way. When these people attempted to communicate with others, staff facilitated this communication in a kind and helpful way.

People were given privacy and their dignity was respected. When people required support, we saw this was offered in a discrete way. One person asked for a staff member to go into their room, the staff member made

sure to check exactly what they wanted and asked permission to open their cupboard to get it. Staff explained how they provided people with dignity during personal care tasks, for example encouraging people to do as much as possible themselves and covering their private area with towels while supporting elsewhere.

Nobody at the service used an advocate. The poor quality of mental capacity assessments and lack of staff knowledge meant people may not receive an advocate when needed. The manager was aware of local advocate services and was aware that people may require advocacy services as their mental capacity was reviewed.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not provide enough detail on people's diverse needs. This could make it difficult for staff to respond appropriately. For example, staff told us that one person identified as bisexual. Their care plan identified that they could struggle with sexual consent but it did not consider their sexual orientation. The guidance provided in the care plan was not sufficiently detailed for staff to support the person appropriately. Care plans also did not provide sufficient information on religion and staff had varying knowledge of people's religious needs. For example, one person advised they attended church with relatives however staff did not recognise anyone as having a religious lifestyle.

People were provided with some opportunities to follow their interests. One person had expressed an interest in work, and had been supported to access a voluntary role. They spoke positively about their work and the opportunities it had provided. They said, "Staff take me and pick me up. Always on time and they ask how it's gone." Another person's care plan identified that they liked to feed the birds. We saw this had been supported. While people told us that they engaged with activities regularly, we saw minimal documentation on what activity had occurred and the impact this had on the person. Further work was required to ensure activities were suitably documented and reviewed to ensure the activities were enjoyable, person centred and supported people to lead active and meaningful lives.

The service had submitted the Provider Information Return a year before our inspection. Within this they explained that they wished to improve and create people's goals for the year ahead. We found people were engaged with short term activities, but these longer-term goals had not been embedded in the service. The new manager had begun to implement longer term goals for people. We saw one person had recently moved to a room with a kitchenette facility and was being encouraged to manage their own cleaning. The manager told us, "I hope in a few years everyone will be moved on and independent. That would be the dream. I want to fulfil people's potential." A member of staff told us, "[Manager] has really good plans and is supporting people in a way that is more independent. That's not really been the ethos before. Some people have been here for years without the goal to leave, so I'm happy that we have that to work towards now. It makes it worthwhile." Further work was required to ensure people's longer term goals were documented and their progress assessed.

The Accessible Information Standard (AIS) is a framework put in place from August 2016. It is a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The manager was aware of this requirement. We noted that there was accessible information newly placed around the home, and people had been involved with creating this. For example, meal plans were in picture format. A person told us "I have decorated the walls", they showed us that staff and people's faces were stuck on the wall in an accessible way. They told us that it helps people remember who is who in the building This accessible information had only just begun with the new manager, so will require further long term embedding into the service. We will assess the impact of this more at our next inspection.

Formal complaints had been responded to in line with company policy. A new accessible complaints

procedure for people living at the service was now in place. This could allow better engagement with people living there. Since this had been in place, no recent complaints had been received so we could not assess its effectiveness. This accessible format is new so requires longer term embedding to be better assessed.

At the time of the inspection, there was no one receiving or had recently received end of life support. We are therefore unable to comment on the effectiveness of End of life support at the service

Inadequate

Is the service well-led?

Our findings

The provider had not ensured the safe running of the service during the absence of a registered manager. The registered manager had left the service In February 2018. In August 2018, a provider audit found considerable concerns about the safety of the service and the outcome was that immediate action was required to resolve issues. We were concerned that despite management absence, the provider had only audited the service six months later. Furthermore, despite assurances to Nottinghamshire County Council, the provider had failed to act on these concerns. At the time of our inspection there were ongoing concerns regarding poor quality care plans, poor incident management, insufficient staff training, environmental risks, poor medicine management, and insufficient mental capacity assessments. These presented a significant risk to those living at the service. After the inspection the provider sent us assurances that these issues were now resolved. We will follow this up at our next inspection.

There was a lack of effective oversight to ensure the safety of people living at the service. There was no management audit of behavioural incidents. Therefore, themes had not been recognised and people had been at risk of harm from themselves and others. A yearly management audit completed in August 2018 identified that care plans needed 'a complete over-hall'. This had still not been completed, meaning staff were without guidance on how to support people. Staff told us they were frustrated by the lack of guidance and records showed that their responses to incidents had then been inappropriate. The lack of effective governance meant staff were not guided on how to respond to behaviours that challenge, inappropriate responses were not recognised or reviewed with staff and people had remained at risk of harm.

Training was out of date in multiple areas and staff told us they were concerned about their lack of knowledge. Staff felt they required additional training to improve their practice. The annual provider audit documented that staff had requested this further training in behavioural support. However, this had not been provided. We were concerned that training was often out of date, and despite staff concerns this had not been addressed.

We found multiple concerns regarding medicine management and cleanliness in the home. Staff audits for medicine and cleaning had been completed and no issues were identified. However, we found significant issues which questioned the effectiveness of those audits. Where staff had recognised an issue, it had not always been resolved. For example, the fire doors were recorded as faulty for over a year and not resolved. These ineffective audits put people at risk of harm.

There was no registered manager in place. The registered manager had left the service in February 2018, and had not returned to work. The service was in the process of registering a new manager. At the time of the inspection, this person had only been in place for a few months. While staff all spoke positively about their involvement, they had not been employed long enough to embed change in the service.

The service showed no evidence of learning and innovation. This poor management resulted in ineffective and unsafe care. Despite being aware of existing concerns, there was no evidence that this had been effectively managed. Staff had fed-back concerns and not been responded to. Incidents had occurred and

not been risk managed. This meant the service had failed to improve.

Input from other professionals was not effectively used. Care plans did not adequately include professional feedback, and a lack of guidance meant staff did not respond in line with evidence based practice. This meant people received unsafe and ineffective care. Where the provider had advised the Local Authority that they would make improvements, we saw minimal change had occurred by the agreed completion date.

The newly employed manager had made efforts to engage the people living at the service. We saw accessible information around the service and the manager told us that they had sent out questionnaires to relatives to gain their input. While recent positive attempts had been made to engage people living at the service, there was no evidence that this had historically happened. Care plans did not include people's input to allow person centred care. The manager explained that this is an area that they felt needed improvement. They explained that they have been getting to know people, and had started engaging them more effectively with reviews. The manager had a good knowledge of people living at the service, however had been in their position a limited time to fully effect positive change.

The service has a legal duty to notify us of incidents that occur at the home. This allows the CQC to monitor and assess risk at a service. Due to a lack of oversight of risks at the service, we had not always been notified of incidents that had occurred. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The poor oversight of concerns and failure to resolve issues is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous Care Quality Commission rating was clearly displayed at the service. This is a legal requirement of the provider.

We have expressed our significant concerns about the safety and governance of the service. The provider has responded by completing an action plan. They have advised that improvements have been made to the running of the service and immediate concerns have been addressed. This action plan was comprehensive and with attached evidence of some resolved concerns. Their action plan notes that all remaining improvements will be made by the end of March 2019. We are unable to comment on the effectiveness of changes made since our inspection, nor how well they are embedded in the service. However, will consider this action plan and changes made during our next inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider has a legal duty to notify the CQC of incidents that occur at the service. They had failed to do this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not always in place. Mental capacity assessments that were in place did not have a best interest decision to guide staff. Staff were restrictive in their practice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The poor management of incidents, insufficient care planning, poor medicine management, and poor environmental control

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had poor oversight of concerns and there was a failure to resolve known issues

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not sufficiently trained to support people