Swanton Care & Community Limited

Darwin Place

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 4, 7 and 9 August 2017. The first day was unannounced and the second and third days were announced.

Darwin Place Residential Home offers accommodation for up to seven people with learning disabilities or autistic spectrum disorders. There were seven people living at the home at the time of our inspection. The home consists of a main bungalow where four people live, and three individual flats.

The service was previously inspected on 23 September 2016 and was rated good in all areas.

At this inspection, we found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person centred care, safe care and treatment, safeguarding people from abuse and improper treatment, staffing and good governance.

There was not a registered manager in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager in post who was available on all days of the inspection. This person had been employed by the service since 5 June 2017. They had not yet applied to be registered with the Care Quality Commission (CQC).

People were not fully protected from harm and abuse. Incidents had occurred when people and staff had been hurt. The staff had not followed safeguarding protocols and incidents had not been reported to out-side agencies. Referrals had not been made to the local safeguarding authority when safeguarding incidents had happened. People had not had risks to their health and safety assessed sufficiently to reduce the likelihood of harm or abuse occurring.

The management of medicines was unsafe. People did not receive their prescribed medicines at the right times. Medication administration records (MARs) for some people had been signed to indicate they had received prescribed medication which had not been given. Handwritten MARs had not been signed by two staff to ensure the accuracy of the information recorded and some MARs did not provide instructions about the use of medicines. This put people's health safety and wellbeing at risk.

People were not always supported by staff who had the required knowledge and experience to enable them to lead a happy life. People were not always supported in a respectful manner by staff. People's confidentiality was not always respected.

Care plans did not contain all the information needed to make sure people received the care and support that they needed. People's health needs were not always monitored when required to prevent deterioration in chronic conditions.

People were not provided with information on how to complain.

There was no registered manager. There was a lack of continuity in the management of the service, which had impacted on people, staff and the service provided. The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service, and take prompt action where poor care was identified. The provider had not informed CQC of important events that occurred at the service, in line with current legislation.

The overall rating for this service is Inadequate which means it will be 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.

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.

People were not protected from harm and abuse. Incidents of abuse had not been reported to out-side agencies.
Risks to people were assessed but the information did not always enable staff to know what action to take to keep people safe.
Accidents and incidents had been recorded but not investigated or analysed to reduce the risks of further events. Medicines processes were not safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had received all the training they needed to meet people's needs. People were not fully supported with their health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect that promoted their independence and autonomy. People's confidentiality was not always supported.
Staff did communicate with people in a caring and compassionate way. Some staff knew people well and knew how they preferred to be supported

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive the care and support they needed to meet their individual needs.
People's health needs were not always monitored to prevent deterioration.
People did not have access to easy read complaints procedures.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of continuity in the management of the service, which had impacted on people, staff and the service provided.
There was no registered manager.
The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.
The provider had not ensured CQC and the local authority were informed of incidents in the home.

Darwin Place

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.

The inspection took place on 4, 7 and 9 August 2017. The first day was unannounced, and the second and third days were announced.

The inspection team consisted of two inspectors.

Prior to our inspection we had received information of concern from the healthcare professional teams who supported the service. They shared concerns about the safety and well-being of the people who lived at the home. In addition, we received whistleblowing concerns from staff working at the service. We used this information and responded by undertaking this inspection earlier than was planned. We also used this information to formulate our inspection plan. This included previous inspection reports, information received and statutory notifications. A statutory notification is information about important events which the provider is required to send us by law. On this occasion, we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant with us.

People living at Darwin House had varying ability to express opinions about the support they received. During our inspection we spent time with people in the communal areas of the home. We spoke with six members of support staff, the manager and the business support manager. We also spoke with four external health and social care professionals who supported the service. We looked at the care records of four people who lived at the home, and a range of records relating to the running of the service including staff files and audits carried out by the manager and registered provider.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2016 the provider was rated Good in Safe. Following this inspection we have changed the rating to Inadequate based on our inspection findings.

People were not kept safe from avoidable harm and abuse. Healthcare professionals who had involvement and contact with the provider told us that they had concerns about people's safety and support at Darwin Place. We had also received whistleblowing concerns that incidents had occurred at Darwin Place when people and staff had been hurt. The staffing and managerial arrangements in place were unable to protect people from harm, fear, distress and injury.

At this inspection, we found that the provider had failed to implement systems and processes to identify and respond to areas of risk that could expose people to the risk of harm. People had been involved in incidents that had or could have affected their health, safety and welfare. We found that one person was presenting with severe behaviour patterns which were not managed by the staff team. As a result, people were being assaulted and emotionally abused on a regular basis. We saw three other people living at the home had begun to display new anxiety or agitated and aggressive behaviour. Staff we spoke with felt this was a direct result of the disruption to their daily life at the home. One staff member told us, "[Person's name] was doing so well. Since [other person's name] came, they have regressed in their behaviour."

We asked staff about people who could display behaviours that challenged. We asked how they recognised any potential 'triggers' for these behaviours. Some staff members showed an understanding of people they knew well. They could describe ways in which they would try to calm people's anxieties and reduce instances of behaviour that challenged. However, this was not consistent across the staff team.

We looked at the support plan for one person. The plan stated, "[Person's name] is vulnerable to physical harm from other people being supported at Darwin Place. Staff need to be vigilant when [Person's name] is using communal areas of the home." We saw that this person had been subject to physical and emotional abuse from other people who live there on seven occasions between 26 July and 4 August 2017. This person had been further assaulted on two occasions during the weekend between our first and second visit . This meant that, despite our concerns for people's safety at our first visit, the provider continued to fail to keep people safe. With regard to these incidents, one staff member said, "[Person's name] is a sitting duck. I have seen [person] be assaulted a few times. It happens so quickly, we do not have the chance to stop it."

We also saw that another person had four recorded incidents of abuse towards them from 17 July to 7 August 2017. We looked at the support plan for this person, who lived with high anxiety levels. One part of their risk assessment stated, "[Person's name] will get very upset if they witness any incidents or challenging behaviour from other people we support at Darwin Place. If they do, it may cause them to self-harm. [Person's name] self-harms by clenching their fist and hitting their jaw." We spoke with a staff member who told us that, since the recent admission in the home, the person had begun to hit their jaw as described. This showed the provider had failed to protect this person from avoidable self-harm.

We saw staff had recorded when these incidents had happened. However, there was no information recorded about any root cause analysis. This is a recording of what the person was doing before the incident started, any triggers and subsequent behaviour. The provider had not supported staff to reflect on why the incident may have occurred, or what action to take to make sure people were protected. Staff were trying to manage each incident but a lack of oversight as to the reasons meant that incidents continued to occur. This meant that people continued to be at high risk of harm and improper treatment.

People were being exposed to unacceptable levels of risk of abuse. This was because the provider did not have robust processes in place to protect people from abuse and improper treatment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The staff team did not follow good practice guidance from professionals and adopt control measures to ensure identified risks were as low as was reasonably possible. We saw that risk assessments did not give clear guidance to explain to staff how they should support people consistently in a way that suited them best. For example, we looked at a risk assessment which stated, '[Person's name] may display 'dangerous levels of behaviour'. The risk management plan said, "When at dangerous levels of behaviour, [person's name] has been known to hit staff supporting them." It went on to state, '[Person's name] has a secondary intervention scale which documents behaviours [person] may exhibit and required staff responses.' This secondary intervention scale was not available to read. There was no information for staff about what the dangerous behaviours were, or what action was required to reduce the person's ill-being. In addition, the risk assessments in place included, "[Person's name] is unable to cope with loud noises or a busy, crowded environment. [Person's name] is unable to interact with others in a group setting and will feel insecure and will then take up a dominating role." We saw that the person was, initially, admitted into the main house. Because this was an area which was busy and crowded at times, the person had been exposed directly into an environment already identified as a trigger for their behaviours.

Some staff were able to say how they would support people in these situations but other staff were unsure. The service was currently using very high levels of agency staff to provide increased staffing levels. A large number of agency staff were supporting people on a day to day basis. This posed a real risk that staff would not take the appropriate action to keep risks to a minimum as there was insufficient guidance for them to follow. The manager was not able to confirm that all the agency staff had the required knowledge and experience needed to support people with very complex needs.

We spoke with staff about how the protected people from abuse. They told us they had received training to deal with safeguarding matters. We asked staff to give examples of abuse and they were able to describe the types of abuse that may occur. Staff also demonstrated an understanding of signs and symptoms of abuse and explained how they would report these. They said they had reported their concerns about the current situation to the manager as required. However, we saw that the manager and the provider's senior management had not reported these incidents appropriately to the local authority or CQC. Referrals had not been made to the local safeguarding authority when safeguarding incidents had happened so they were not aware of them.

The provider did not have sufficient guidance in place to safely support people with their behaviour. Risks were not reduced and mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008

Medicine processes in the service were unsafe and placed people at risk of poor care and avoidable harm. Records about medicines were not well maintained. We found there were gaps in recording and missing

signatures, so it was not always possible to tell if medicines had been given. In addition, we saw that counts of the medicines were not always being undertaken. Medicines in stock were not being carried forward when new medicines were brought into the home. This meant that it was not possible to be sure that the correct number of medicines were in place, and that people had received their prescribed medicines. We also found that medicines wee being kept in different places. This compounded the difficulty in monitoring medicines in the home. We also found that newly prescribed medicines had been handwritten on MARs and had not been signed for twice by staff. Handwritten entries on MARs should not happen as a routine. If it is required in the case of new medicines being prescribed, then two staff should check them in and then they should sign for them. This is a safeguarding measure to ensure correct amounts of medicines were in provided. we saw that this was also a requirement within the provider's own policies.

We also saw staff had tampered with the sealed medication in the racks. They had opened the monthly medication cycle to take medicines which were in short supply instead of ordering more from the GP. This meant they were likely to run out before the end of the monthly cycle.

There was a previous medication audit available however this was not dated or signed. The result of the audit was 45%. We were unable to locate any action plan and there appeared to have been no actions taken. We also found that the medicines were stored in a small room with no hand washing facilities. Temperatures of the room and medicine fridge was not always recorded daily.

One person had been prescribed a sedative medicine to be used as required. We saw that the MARs for this medicine had a hand-written entry to change the dose from 10mgs to 5mgs. The MARs was not signed, nor confirmation seen of who authorised the reduction and why.

We found that two people had been prescribed medicines which were used to treat severe anxiety. They were prescribed 'as required (PRN)'. There was no record of how many of the tablets had been received, or what number of tablets had been carried forward form the previous months MARs. There was a PRN (when necessary medicine) protocol in place for each person to advise the staff team what symptoms to look for which would make them consider administering the medicine. However the instructions were not very detailed for the symptoms staff should look out for. For example, one said 'used for depression', but did not state how staff could recognise the person was depressed. The MARs did not state when people may need to take their medicines, or how many they could take in a 24 hour period.

We found discrepancies in the amounts of some medicines we looked at. For example, with one person's pain relief tablets, the amount in stock stated 120. We found that there were 126 present. The dose for the tablets was two tablets as required for pain. This meant that the tablets had been signed for on three occasions where they had not been given. This also meant that we could not be sure the person had received pain relief when required.

We were informed that only staff who had received training administered medicines. We were also told that all staff were checked for competence in administering medicines by the provider. They stated that this was undertaken every year. However, the manager was only able to find the documentation for one staff member.

The provider had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008

The provider failed to identify the number of staff required to support the admission of two new people with complex care and support needs. As a result additional agency staff were required in great number. These

staff did not always have the necessary training to be able to support and manage people in a safe way and protect them from harm. Where the home's own staff were deployed to support the two people who were receiving 2:1 support, other people are being supported by agency or very new staff. One staff member told us, "The agency staff are just for general care. They take the less challenging service users." This exposed people to an increased risk of harm to their health, safety and wellbeing as staff were not always able to promote safety and prevent harm.

We also found instances where, despite the 2:1 or 1:1 staffing support in place, the skills and competencies of the staff team were insufficient to prevent assaults on other more vulnerable individuals. Some of these assaults happened during the night, despite two staff members supporting the person instigating the assaults. The night staff team consisted of two people to support one person with significant support needs, and two other staff. We were told that staff checked people living in the bungalows at different times. For example, one person required checking every 15 minutes, another was every hour. No written record of these checks being made was available. Staff told us that they did not record any checks during the night.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2016 the provider was rated Good in Effective. Following this inspection we have changed the rating to Requires Improvement based on our inspection findings.

People living in the main house at Darwin Place, were not receiving effective care and support which promoted a good quality of life.

Staff were supported to access much training as part of the provider's learning and development processes. We spoke with staff to check they received sufficient training to enable them to deliver safe and effective care. Staff explained they had received training in areas such as safeguarding, autism awareness, first aid and fire training. One staff member told us they had learned much about supporting people with epilepsy. They said, "I attended a day course. It was very informative. I was with [person's name] when they became ill in the community. My training kicked in straight away and I knew what to do." The core staff team had received training in how to support people who were exhibiting behaviours which challenged the service. We saw that this training had been booked for the new staff and for some of the agency staff working in the home. We did see, however, that the new staff were still working through their induction process. This, coupled with the high use of agency staff, mean that half of the staff team did not have the necessary skills and knowledge to support people effectively.

We spoke with two agency workers. Both told us that they had been supported by other staff when they worked in the service for the first time. We discussed with the manager how the new staff and agency workers were able to learn about the people they were supporting. The manager said that people were required to read the care plans and to sign a memo to say they had done so. Care records we checked showed that this was not always happening. For example, one person's care plan records showed four signatures out of 19 staff. The manager also said that the staff team communicated any changes during handovers.

We saw that the handovers were discussions between staff. There was not a handover sheet for staff, or a record of what was discussed. We looked at the communications book and saw that there was no entry since 14 February 2017. One staff member told us, "The communication is poor. We used to have computer tablets so we could write our reports when working in the bungalows. They broke and were never mended. If something happens down in the bungalows. We can't always get up to the office to record it." Another staff member said, "There are no notebooks or diaries so that we can make notes. We end up writing from memory sometimes." This meant that essential information was not being shared between staff teams.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 people lack mental capacity

to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Staff told us, and we saw from the training matrix, that the core staff team had received training in MCA and DoLS. Staff we spoke with were able to tell us about the five key principles for assessing capacity. We saw that, where required, people's mental capacity was assessed. Staff supported people to make their own decisions and sought people's views where possible. However, the increased volatility in the service had meant that, at times, decisions needed to be made on people's behalf in order to keep them safe. These actions included supporting people to leave the communal areas to be away from conflict in the service. We spoke with staff about this issue. One staff member who had done this said, "I had to make a quick decision to go out of the lounge with [person's name] because they were getting upset. It was in their best interest."

We observed one member of staff talking with one of the people who lived in the bungalows. We observed the staff member encouraging the person to think about what they wanted to do with regard to going out. They were given the time and space to consider the options available to them. Once they had made their decision, the staff member supported the person to do as they had decided. The interaction was made in a kind and courteous manner which respected the person's point of view.

We saw that one person was being given their medicines covertly in their food. There was no best interest decision recorded about this. We asked the senior manager about this decision. They commented that the staff told the person their medicines were in their food, so it did not count as covert medicines. The decision to administer medicines in this way did not follow good practice guidelines on managing medicines in care homes.

We saw that one person's financial decisions were being made by their relative. The manager was not able to confirm to us that the relative had power of attorney to take this responsibility. They told us that the person's relative said they had but they had not seen a copy of the document.

People were supported to eat and drink a balanced diet. Meals were prepared when people wished to have them. The three people living in the bungalows were able to prepare and cook their own meals with support from the staff team. Within the main house, people were supported to choose their preferred meals. One person had been assessed by the Speech and Language Team (SaLT) as they had difficulty swallowing. They had been assessed as requiring a softer diet and thickened fluids. Staff were able to tell us how they prepared this person's meals and drinks to mitigate the risk of choking.

People were supported to access healthcare services to monitor their health. For example, people were supported to attend hospital appointments and NHS healthcare screening services. People were also supported to attend dentist, optician and GP services as required. Some people in the home were receiving high levels of support from the Intensive Support Team (IST) and the community learning disability nursing services. The IST is a specialist community team who support people with complex needs to feel settled when they move to care homes.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in August 2016 the provider was rated Good in Caring. Following this inspection we have changed the rating to requires Improvement based on our inspection findings.

People did not live in an environment that afforded them respect and which undermined their dignity.

We saw people spent time in a noisy and busy environment. One person was seen to be showing signs of anxiety and agitation. We read this person's support plan. The plans stated, "Keep my environment noise free so I can focus on what you are saying." Also, their plan called, "Things that upset me," stated that they did not like their environment to be too noisy or loud as it made them anxious. On all three days of our inspection we saw this person sitting in a noisy and busy environment which they were unable to escape from. They were seen to be exhibiting their understood signs of anxiety and ill-being. They were also subjected to opportunistic assaults and verbal abuse which frightened them. Although staff tried to prevent this happening, they were not always able to improve the atmosphere or reassure the person in a caring way.

People's privacy and confidentiality were not always respected in the home. We saw that handovers between shifts happened in the kitchen which was adjacent to the dining room where people sat. We saw that people were able to listen to everyone's details being discussed. These included details of people's hospital visits and behaviours during the day.

We observed occasions when some staff were caring. We observed staff talking with people respectfully and offering help. We saw staff were patient when they interacted with people and helped them in a gentle way. Staff did not rush people and were thoughtful when they spoke with them. For example, we spent time with one person and their keyworker. We saw that they enjoyed a good relationship. We saw how the staff member had a calming influence on the person. The person listened to their keyworker and was able to modify their responses to others with their support. The staff member told us, "We have worked together for some time. I know how [person's name] responds to overstimulation and we work together to reduce it."

We saw that, where possible, people were involved in making decisions about their own care and support needs. People who lived in the three bungalows were supported by a core staff team who knew them well. Staff spoke kindly and respectfully about people who lived at the home. Staff told us they cared for people and wanted to do their best for them. One staff member said, "It is all about these guys. They are like family. If you don't have the care and compassion you shouldn't be in this job."

We discussed the provision of advocacy services with the manager. They informed us advocacy support was arranged if people did not have close family. They told us that they had asked the local authority to provide advocates for two people living at the home. At the time of the inspection, these arrangements were not concluded.

Inadequate

Is the service responsive?

Our findings

At our last inspection in August 2016 the provider was rated Good in Responsive. Following this inspection we have changed the rating to Inadequate based on our inspection findings

Not all people who used the service received personalised care that was responsive to their individual needs. We saw that people's individual preferences and support needs were documented. However, we saw many examples of their documented preferences and support needs not being respected. When people displayed behaviour that could be challenging to other people and staff, incidents were not consistently and clearly documented. There was limited detail about what triggers might lead to a person becoming distressed. There was limited information about the early signs to look for or what action to take to support the person in a safe way. For example, one person had been admitted to the service as an emergency admission. They had lived at the service previously. We found that staff relied on previous knowledge of the person to plan their care, even though the person's needs had changed. There was guidance in the initial care plans to which showed that the person needed a quiet and stress-free environment to prevent escalation of aggression and agitation. The person had been admitted to an area of the home which was noisy and volatile. As a result of this, the person had displayed avoidable behaviour patterns which caused stress and upset for themselves and others living there.

We reviewed the health issues documented in another person's care file. Records in the file stated that the person had a health condition which required medicines to be taken on a regular basis. The medicine levels needed to be monitored by way of regular blood tests. There was no record of any blood tests being taken. We asked the manager when the person has last had their blood taken to check this. They were unable to tell us when or if the person's blood had been checked. This lack of monitoring placed the person at risk of harm because too much of the medicine in their blood could cause heart problems.

Another person was living with a chronic joint condition which caused them high levels of pain. Records showed that, when the person was experiencing high levels of pain, their ability to self-regulate their behaviour was reduced. We saw that the person was prescribed medicines to take for their pain, but they were not effective. The manager told us that the person had been admitted without a pain management plan. They also said they had requested the IST to provide a plan for this. This discussion took place 26 days after the person was admitted to the service. The manager had not arranged for a doctor to assess the person's pain at the service. This showed a lack of oversight into the person's pain and the effect it had on their daily life. This also meant that they had been subject to unnecessary pain and suffering.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that no complaints had been raised about the service. The process for making and responding to a complaint was clearly set out in the provider's complaints procedure. The business development manager told us that the provider had easy read complaints procedures on their system. However, no such procedures were available in Darwin Place for people to read.

People were supported to maintain relationships with their families. One person had gone away with their family for a few days. Other people were seen to be supported to go out into the community with their support workers. People were also encouraged and supported to attend college. We saw staff preparing to support one person to have a special birthday celebration. Staff and other people who used the service were intending to dress up for the party. We saw that other people living at Darwin Place were being encouraged to be involved in the preparations, including wrapping presents and making posters.

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2016 the provider was rated Good in Well-Led. Following this inspection we have changed the rating to based on our inspection findings.

People living at the home were not protected and supported to be safe. This was because of a lack of provider and managerial oversight of the service. Systems and processes in place did not effectively monitor and improve the quality and safety of support provided. There were inadequate auditing systems in place to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home.

We found that the systems to record and monitor accidents and incidents were not effective. We were told, and we saw, that any accidents and incidents were monitored by the senior team at the provider's head office. Outcomes of audits were collated along with the same reports from the provider's other services. This meant that it was difficult to identify areas for improvement as they were lost in the large document. In our discussions with the manager, they were not able demonstrate how they had reviewed the incident reports at home level to look for specific trends. They were unable to tell us what action had been taken to reduce the risk of reoccurrence of assaults in the service.

The provider had a comprehensive set of policies and procedures for the service which were made available to staff. Policies and procedures support effective decision making because they provide guidelines for staff. This included what they could and could not do, what decisions they could make and what activities were appropriate to ensure a safe service. However people and others were put at risk because the providers policies and procedures were not being followed as required. This included monitoring the quality and safety of the service. For example, the provider's 'integrated admission and discharge policy' clearly set out the processes required to be followed when admitting people to the service. We found that the policy was not followed in relation to the two recent admissions to the service. The provider admitted two new people to the home since 26 June 2017. Both of these individuals had complex and challenging behaviours. Their preadmission process failed to adequately assess these individuals to ensure the provider could safely meet their needs. The provider also failed to consider how staff could care for these two individuals and at the same time keep other people in the home safe and protected from harm. These failings created a volatile situation which directly impacted the safety of people in the home.

There was a lack of good governance and oversight in the monitoring of medicines administration, medicines recording and storage. The manager told us that they were aware of some of the issues we found with medicines in the home and that they were dealing with them. However, they were unable to show us what action they had taken. An audit was undertaken on our second day with the provider's quality and governance manager. They recognised the shortfalls and prepared an action plan for improvement of the medicine processes in the home.

We had received a number of whistleblowing complaints from staff members. These complaints highlighted concerns found at the inspection. We also received complaints from healthcare professionals who worked with people at the service. We discussed the content of these complaints with the manager on our first day

at the service. The manager said that they felt the complaints were unjustified and did not understand why they had been made. They told us that they felt the people at the home were safe.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 201) 2014.

Some audits had been carried out recently on care plans and risk assessments by the team leaders in the service. Although some care plans and risk assessments had been reviewed and updated, they continued to lack the required detail. This meant that people were still at risk of not receiving safe personalised care and support. This had not been identified as an issue as the outcomes and conclusions had not been looked at by the manager.

Darwin Place had not had a registered manager since October 2015. Four managers had been in post since then but none had come forward to register with us. We had been told that the present manager had begun the process to register with us as manager. We checked this with our registration colleagues who informed us that no application had been received.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC check that appropriate action had been taken. Notifications had not been submitted in line with guidance. For example there had been a number of reportable incidents in the service. This was where people had been hurt or police had attended the service. These had not been reported to CQC or to the local safeguarding authority.

The provider failed to notify CQC of reportable events in line with guidance. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us that they felt the new manager was supportive and listened to them. One staff member said, "We have had so many managers here. We get used to one and they go. We hope that we can get a manager who will stay. We need that stability." Another staff member said, "[Manager's name] spends time with the service users. They care about them and us (staff)." We saw that the manager had begun to implement staff supervisions and meetings. They told us, "I have been canvassing the staff for their views on what they would like to see as we move forward. It is important they are involved."

We saw that the registered provider was displaying the home's current rating as required by the regulations.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care failure to assess, identify and monitor peoples healthcare needs. this failure placed people at risk of deterioration in their health conditions.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment failure to keep people safe from avoidable harm, abuse and fear.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment failure to keep people safe from abuse and assault.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance failure to identify, monitor and act upon poor care and support which placed people at great risk of

avoidable harm and fear.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing failure to provide staff who had the knowledge and experience to support people safe and protect them from harm and fear.

The enforcement action we took:

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.