Chase Community Homes

Ferndale

Inspection report

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08 April 2016

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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

This inspection took place on 04, 06, 07 and 08 April 2016 and was unannounced. At the last inspection completed in May 2015 the provider was meeting all of the legal requirements that we looked at.

Ferndale is a residential home that provides accommodation and personal care for up to 13 people with autism and learning disabilities. At the time of our inspection there were 11 people living at the service. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found widespread and significant shortfalls in the service.

People were not protected from harm due to managers not recognising and reporting safeguarding incidents to the local authority. Risks to people were not always identified, recorded and known to staff; therefore risks were not always managed and reduced in order to keep people safe. Medicines were not always managed safely.

People were not always protected due to unsafe recruitment practices. People's needs were not always considered when training staff members. Staff were given access to training but had not been trained in important areas such as risk or autism awareness. Staff member's competency was not checked to ensure they were effective in their roles.

People were enabled to provide consent to day to day tasks and activities. Where people did not have the ability to provide consent we found that decisions were not always made in line with the Mental Capacity Act 2005. People were supported to have sufficient quantities of food and drink. People's day to day health needs were met and they were supported to see healthcare professionals when required. Where more specialist support was needed managers were not always proactive in seeking this support.

People were not always supported in a caring, dignified and respectful way. The staff team listened to people's basic choices and preferences and gave day to day options for people to choose from. The provider had not considered ways to involve people in their care plans and advocacy was not always made available to people. People's care and support plans did not always reflect their needs and preferences. People could access a structured activities programme although minimal work had been done to develop individualised programmes of activity for people based on their own preferences.

People were not supported by a strong management team who could identify and manage risks within the service to keep them safe. The provider had not developed effective quality assurance systems to ensure that issues within the service were identified and improvements were made where required.

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service was 'Inadequate' and the service was therefore placed into 'Special measures'. Services in special measures are kept under review. Following the inspection we took urgent action to cancel the registration of the provider. At the time of the publication of this report, our action had been completed and there were no people living at the service.

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 as the risks to them were not identified and appropriately managed. Significant incidents were not reported to the local authority in order for plans to be developed to keep people safe. Medicines were not always managed safely and recruitment practices were unsafe.

Is the service effective?

Inadequate

The service was not effective

People were not protected by staff who had the skills and training to support them effectively. Decisions about people's care were not always made in line with the requirements of the Mental Capacity Act 2005.

People received sufficient amounts of food and drink. People's day to day health needs were met although access to specialist health and social care support was not always sought promptly when required.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always treated in a dignified and respectful way. People did not always receive support in a caring way that fully considered their needs. People were not always treated in a dignified and respectful way. People were able to make some day to day choices about their care.

Is the service responsive?

Inadequate

The service was not responsive

People were not always enabled to be fully involved in the planning of their care. People's care and support plans did not always accurately reflect their needs and preferences.

People were able to access a structured activities programme

although this was not always tailored to people's individual needs and preferences.

Is the service well-led?

Inadequate

The service was not well-led

People were not supported by a strong management team who could identify and manage risks within the service to keep them safe. The provider had not developed effective quality assurance systems to ensure that issues within the service were identified and improvements were made where required.

Ferndale

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 4, 6, 7 and 8 April 2016 and was unannounced. The inspection team consisted of four inspectors. As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority and clinical commissioning group. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spent time with all 11 people who lived at the service. Some people living at the service had complex needs and were unable to share their views with us about their care. To help us understand the experiences of people we spent time observing care and interactions between people and staff members. This helped us to understand the experience of people who could not talk with us. We spoke with nine relatives, the two providers, the registered manager, the deputy manager, acting deputy manager and nine members of staff; including care staff, the cook and the maintenance person. We also spoke with health and social care professionals. We reviewed records relating to people's medicines, four people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance. We carried out observations across the service to better understand the quality of care people received.

Inadequate

Is the service safe?

Our findings

People were not able to share their views about how safe they felt living at the service so we completed observations of the care provided. We observed that risks to people were not always identified and managed appropriately in order to protect them from harm. For example, we identified from looking at one person's care plan that they were at risk of choking or asphyxiation. Two out of three members of staff we spoke with were not aware of the risks to this person or of the guidance in their care plan about how to keep them safe. The registered manager and deputy manager were not certain what the current risks to this person were. One member of staff told us the risks we had identified were current and it was important the guidelines were followed to keep the person safe. We saw that measures outlined to keep the environment safe, such as ensuring there were no drawing pins in notice boards were not followed. We saw that their bathroom door had been locked by staff to prevent them ingesting toiletries. However, the laundry door this person walked past was open with ingestible items such as hand wash accessible. The registered manager told us they would ensure the laundry door was locked immediately and we saw that risk factors such as drawing pins were removed when we identified this risk. Staff and management were not aware of all of the potential risks to this person and therefore did not know how to keep them safe from potential harm. We were told by the registered manager that other identified risks to this person would be addressed immediately. During discussions with the provider shortly after the inspection we found that risks continued to be inadequately addressed. We saw that some risk assessments were not person specific and did not identify how to manage risks to particular individuals. For example, we saw that risk assessments were the same for some people with only their names changed. The provider had not ensured that risk assessments were effective and staff had the required knowledge to protect people from harm.

Where people's needs and the risks to them changed, care plans and risks assessments were not always updated to reflect the current risk and how to safely manage this to protect them. This resulted in the risks not being adequately assessed and managed. For example, one person had recently been discharged from hospital and they now needed two staff members to assist them in moving around the service. We saw during the inspection that two staff members were not able to safely assist this person with standing from a chair. The person was stumbling and falling back into their chair. We asked the registered manager about the assessment of the risks to this person when mobilising. They confirmed that they had left a note in the staff communications book to say that two people were needed; however, the registered manager advised that a plan to outline the safe mobility of this person had not been completed. In the week following the inspection we learned that this person had fallen and suffered a fracture. The provider was not ensuring that risk management plans were updated and that staff were provided with guidelines to manage the changing risks to people.

Some people who lived at the service may demonstrate behaviours that could challenge others and could cause harm. We spoke to staff members, the deputy manager and the registered manager about how they monitored and analysed behaviours in order to identify triggers. The identification of triggers can enable providers to develop systems to assist with the reduction of behaviours that challenge, management of any associated risks and protect people from harm. We were told by the manager, deputy manager and staff that there were no systems in place to effectively identify the cause of behaviours and as a result

appropriate prevention strategies were not in place. We found that the manager was not proactively involving social care professionals and behavioural support teams to assist with managing risks associated with certain behaviours. We saw that staff did not always appear to have the skills and knowledge required to safely manage behaviours that challenged. We saw from incident records and were told by staff and managers about circumstances where people had caused harm to others and staff had not sufficiently considered the risk of the situation escalating or reoccurring. There were no plans in place to provide guidelines to staff about how to reduce the likelihood of these incidents occurring and how they should keep people safe. We found that staff had not been trained in the areas of physical intervention, autism and risk management. It was confirmed by staff that everyone living at the service had a diagnosis of autism and many demonstrated behaviours that could challenge. The provider had not ensured that staff members were safely managing risks to people and behaviours that challenged in order to keep people safe.

This was a breach of Regulation 12 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

We looked at how the registered manager ensured that antipsychotic medicines that could be given on an 'as required' basis were administered appropriately and safely. We found that medicines administration records, daily sheets and incidents records did not match. For example, one record outlined that a person had been calm all day and another said that the person's mood had been 'good'. There was no indication on these records that the person's mood had changed and they required their medicines, however, we identified from the person's MAR that they had been given antipsychotic medicines to control their behaviour on these days. We discussed this with the registered manager and acting deputy manager who were not able to provide an explanation. We asked one staff member how they would know when to give this person their medicine and they could outline the instructions given by the psychiatrist. The registered manager advised that staff should obtain authorisation from the registered manager or from the 'on call' service before giving these medicines, however, due to the inaccurate recording they could not be certain that this had been done. The provider had no method in place to check that these medicines were administered safely and appropriately.

People were not protected by effective management of medicines in the service. We checked the stock levels for eight medicines and found that six of these did not match the medicines administration records (MAR). The acting deputy manager investigated these discrepancies during the inspection and explained a range of issues that had not been effectively managed. These included medicines not being booked into and out of the service accurately. The provider had failed to ensure that there was an accurate record of the medicines being stored on the premises. We found that staff didn't have sufficient knowledge around the storage of medicines. For example, we asked staff responsible for managing medicines what temperature the fridge should be if it was in use. They did not have an accurate knowledge of the requirements for safe storage. The registered manager was not ensuring that staff had the required knowledge to keep medicines safe and effective.

We found that some people had additional 'homely remedies' including items such as vitamins or lip balms. The registered manager had not checked with the person's GP or pharmacist to ensure the items were safe for the person to use and that any possible effects on existing medicines had been identified. Where entries had been handwritten onto the MAR they had not been checked and double signed by a second person as recommended by national guidelines. The provider was not ensuring that any homely remedies administered to people by staff would not cause people harm or impact on the effectiveness of existing medicines.

We looked at the training records supplied by the manager and found that the manager responsible for

overseeing medicines management did not have current, 'in date' training in medicines. The provider had not ensured that managers responsible for managing medicines had the required skills to ensure this was managed safely.

This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

People were not protected from potential harm due to safeguarding concerns not being identified and reported to the local safeguarding authority. As a result of this plans were not in place to protect people from potential harm following specific incidents. Staff members we spoke with were able to describe signs of potential abuse and how they would report any concerns they had about people. They were able to describe what action they would take if they had concerns about the actions taken by managers or if they needed to report concerns outside of the organisation and 'whistleblow'. Whistle blowing is when staff members would call an organisation such as the local authority or CQC to share concerns about the service. However, we found that in practice, staff and managers were not recognising events as potential safeguarding concerns. As a result of this, they were not taking the required actions to protect people. For example, we found multiple incident records that identified concerns about people living at the service that had not been reported to the local safeguarding authority. Therefore investigations had not been completed and measures had not been put into place to keep these people safe. The provider had failed to ensure that people were protected harm following incidents of concern.

We spoke to the provider, the registered manager and the acting deputy manager about the concerns that we had identified and found that they did not have the required knowledge to identify and report safeguarding concerns. We found that the provider's safeguarding policy did not adequately outline to staff and managers how they needed to protect people and it failed to highlight how to recognise and report concerns about people. The provider had not developed adequate systems and processes to protect people from harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People living at the service were not able to share their views about whether there were sufficient numbers of staff to support people. Relatives and staff members told us that they felt there were enough staff members to meet people's needs and this reflected what we saw during the inspection. We did find however that improvements were required in order to protect people through safe recruitment practices. We found that staff member's employment histories had not always been thoroughly checked. Some references obtained from previous employers were basic personal references and did not provide detail of the staff member's competency in the role. As employment histories were not clearly recorded, gaps in employment were not clear and it was not clear if the last employer had been contacted for a reference.

We found that staff members were starting work without a check on their criminal history having been obtained. The manager and staff members told us that staff members were not able to complete any personal care while this check was pending, however, they did work with people living at the service. We confirmed with the manager that they had also not checked whether staff members had been 'barred' from working with vulnerable people before they started work. The provider had not ensured that there were safe recruitment practices in place to ensure that people were kept safe in their home.

Inadequate

Is the service effective?

Our findings

People were not always supported by staff who had the skills and knowledge to support them effectively and safely. Relatives told us that they felt staff members had the required skills and training to support people effectively. One relative told us, "I have seen the training schedule and there is a lot going on for staff." The registered manager provided us with information about staff training and we saw there were some key areas in which staff had not been trained. For example, we saw staff had not been trained in areas such as physical intervention, risk assessment, nutrition, autism awareness and Makaton. Staff confirmed that everyone living at the service had autism and some used the communication system Makaton. In addition, people using the service sometimes displayed behaviour which may cause harm to themselves or others. The registered manager confirmed that they did not check the competency of staff members to ensure the training they had received was implemented effectively and that staff had the skills needed in their role.

We found the lack of appropriate staff training had impacted on the staff team's ability to support people effectively and keep them safe For example, we found that staff did not always treat people in a dignified way or support them to move in a safe way. We also found staff were not aware of the importance of monitoring people's behaviours in order to develop strategies that responded appropriately to people and reduced the risk to themselves and others. We saw that one person had attempted to injure another person living at the service and this was not being effectively managed. We found other risks where people could cause harm to themselves through ingesting items that were also not being effectively managed. The registered manager told us that additional training was underway, for example in areas such as autism. However, the provider had not ensured staff members received the training they required to be effective in their roles. They had also not ensured staff members had the required competency to support people effectively.

We identified that there was a high percentage of new staff members within the care staff team. We saw that an induction was completed with new staff members. We found that there was time allowed for new staff members to familiarise themselves with care plans and risk assessments. However, as care planning information was not always accurate, staff were not being equipped with the knowledge they needed to provide effective care and support. The provider had not ensured that systems were in place to ensure that new staff members fully understood people's support needs.

We looked at the support people were given to access healthcare professionals when required. We saw that people were enabled to see professionals such as the doctor, dentist and chiropodist. A relative told us, "The home manage all the appointments for the GP and dentist. They arrange for a chiropodist as well. I am always kept informed." We identified that the registered manager did not always proactively seek more specialist support for specific concerns. For example, one person was identified as having issues in mobilising around the service. We asked the registered manager if they had sourced any support from professionals such as an Occupational Therapist and they confirmed they had not. We found that another person was identified as requiring a soft diet and staff mashed their food before it was eaten. Staff told us that this was due to them struggling to chew and potentially choking. We asked the registered manager if

they had sought advice from professionals such as speech and language therapists (SALT) who can provide support for this and they confirmed they had not. People were not always supported to access specialist support when required.

People were seen to provide consent to staff for their day to day care and support needs during the inspection. Staff could explain how they would recognise if someone did not want support and told us they would obtain consent. Relatives told us they felt consent was sought from people before care was provided. One relative told us, "I like the way staff always ask [person's name]. They don't just tell [them] what is happening. [Person's name] can indicate if they are not happy with something."

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that staff and managers were making decisions on behalf of people when they didn't have the capacity to provide consent or make decisions about their own care. However, these decisions were not always being made in line with the MCA. We found that assessments of people's capacity were present in people's care plans, however this covered a generic list of different aspects of people's care. These assessments were the same in each care plan we looked at and were not individual to the people living at the service. The assessments did not reflect people's own individual abilities in making decisions and providing consent. We found that representatives without the appropriate legal authority had consented on behalf of people without capacity. For example relatives had agreed to the use of sound monitors in people's bedrooms to allow staff to hear the movements of people. The people involved had not been consulted and decisions had not been made in line with the MCA. We asked the registered manager, acting deputy manager and staff about how they would make decisions on behalf of people who lacked capacity and they were unable to describe the principles of the MCA. The provider had not ensured that capacity was being assessed in line with the MCA and decisions had not been made in people's best interests in line with the Act.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We were told by the registered manager that where staff felt people were lacking capacity and they had been deprived of their liberty in order to protect their health and well-being, applications had been submitted to the local authority. We were unable to see if the applications made were appropriate as the registered manager had not retained copies of these applications. The registered manager was not able to provide details of the applications submitted and demonstrated that they did not have a sufficient knowledge of the DoLS process.

People were not able to share their views around the food and drink available to them. However, we saw that people appeared to enjoy the food they ate. Relatives told us that they felt the food and drink was good. Several relatives told us that they had requested healthy eating plans to be put in place for their family member due to concerns about their weight. The cook told us that most people in the service were following healthy eating plans. We saw that meals were adapted to take these needs into account. For example, we saw that following a visit to the chip shop, one person ate fish with a salad and without chips. The registered manager was unable to demonstrate that where decisions about food choices were made on people's behalf that this had been done in line with the MCA. Staff were able to describe to us who needed additional support at meal times and we saw this support was provided.

Requires Improvement

Is the service caring?

Our findings

People were supported by a staff team who were caring and told us they were committed to providing the right support to people. Relatives told us that they felt staff made it a homely environment for people. One relative told us, "The service is a home from home and the staff have the resident's best interests at heart". One staff member told us, "I like the way it's relaxed as it's their home". We found staff had not been equipped with the skills to recognise when the support provided was not always caring. We saw examples where the approach by staff was caring and they demonstrated a good rapport with people. We also saw examples where the approach was not caring. For example, we heard one member of staff asking one person if they had, 'got one on them today' and then chastised the person for burping during their lunch. The provider had not ensured that the approach by staff was consistently caring.

People's privacy and dignity was not always protected by staff. Staff were able to describe how they would protect privacy and dignity and relatives told us that they felt privacy and dignity was respected. One relative told us, "The staff knock on doors and give personal care in an appropriate manner". We saw that privacy was respected when completing personal care by taking people to bathrooms and shutting doors. However, staff had not considered that sound monitors used to remotely monitor people's safety needed to be switched off when not in use to protect people's privacy and dignity. We heard several people using the toilet through monitors while we were seated in communal areas during the inspection. We saw that other areas of people's care had not been considered by staff and management in terms of protecting their dignity. For example, people had chiropody treatment in communal areas of the service and people's confidential daily care records were accessible to other people. We saw one person taking confidential files out of a cabinet in a communal area. The provider had not ensured that people's dignity and confidentiality was protected.

We saw that people were not always treated or addressed in a dignified way. We found that the language used by staff was not always dignified. For example, people's behaviour was often referred to as 'aggressive' or 'inappropriate'. When we discussed this term with a member of the management team they told us that behaviour in the service was becoming more challenging and that some people, "used to be lovely". We identified that people's care records did not always describe people in a dignified or respectful way. For example, one plan said, 'I need to be reminded to eat my meals quietly'. We saw that there were public signs in communal areas telling people 'please note no making noises at the dining table while you are eating, shush' and 'no unacceptable behaviours during mealtimes'. We saw another example where one person's care plan outlined that they went to bed at 'inappropriate' times, for example after bathing and mealtimes. We discussed this with staff and the deputy manager and they acknowledged that this was not a dignified way to treat adults living at the service. The provider had not ensured that people were consistently being treated in a dignified and respectful way.

People were supported to make day to day choices. For example, we saw that people were able to decide if they wanted to take part in any activities that were taking place outside of the service. They were offered choices around their food and how they spent their time while at home. We saw that people were supported to personalise their bedrooms. We saw people were able to move around the service independently and

without restriction. People were encouraged to complete their own shopping with the support of staff members in order to promote their independence. We saw that people were also encouraged to maintain independence by completing basic household tasks. We saw that family members were involved in people's care and they were happy with the level of their involvement. We were told by the registered manager that an advocate was in place to provide support to one person. The registered manager had not considered if advocacy support would be appropriate for any other people. They confirmed that they would review the use of advocates across the service.

Inadequate

Is the service responsive?

Our findings

People's care plans did not accurately and consistently reflect their care and support needs or preferences. As a result the staff team were not always responding appropriately to people and ensuring they met their individual care and support needs in an appropriate manner. We found that care plans and risk assessments were not regularly updated following review meetings or a change in people's needs. We found that one person's care plan had not been updated following a recent stay in hospital. Their needs had changed and they needed additional support to move around the service, however, these needs had not been assessed and included in their plan of care. We found staff member's knowledge around people's needs was inadequate and not consistent. When we discussed care plans with the registered manager to establish what information was accurate and relevant to the individual, we found multiple examples where information was out of date or had not been included. We saw an example of a care plan where someone was referred to as becoming 'extremely difficult' when water was on their face as they disliked it. The person's needs had not been thoroughly assessed and alternatives considered if the person became distressed by water. The provider had not ensured that people's support needs were accurately assessed, documented and communicated to the staff team. As a result staff, did not have a consistent understanding of the most appropriate way to support and respond to people so as to ensure their well-being.

People were not included in the planning of their care. We saw that review meetings had been held, however, these were not inclusive of people using the service. We saw that aims had been set in people's care plans; however, these were not the aims of the people themselves. For example, we saw one aim read 'To develop listening skills'. We asked the registered manager and acting deputy manager who had set these aims and they confirmed that they came from review meetings and were not necessarily the aims of the person. We asked the registered manager whether they had considered any alternative ways of involving people living at the service in their care and support outside of formal review meetings. They confirmed they had not. Relatives that we spoke with told us that they were able to attend review meetings and were involved in planning people's care. The provider was involving family members but had failed to ensure that care planning was accessible and inclusive of people living at the service.

People's care was not always personalised and reflective of their individual preferences and needs. We saw that everyone living in the service was supported to get ready for bed at 7.30pm during the inspection. We asked a member of staff if this was done regularly and they confirmed that everyone got into their pyjamas at 7.30pm. The staff member told us that people then had tea and cake and would be in bed by 9.30pm with the exception of one person who went to bed at 10pm. We asked the registered manager why everyone was going to bed at this time without choice being promoted. They told us that they had not checked the preferences of individual people. They said this was how the night time routine had always been done in the service therefore it had simply continued. The provider was not ensuring that the care people received was personalised to the individual people at the service.

People were given the opportunity to participate in an activities programme that ran each week. Relatives told us they thought the activities available to people were very good. One relative told us, "The activities here are really good, in the last place [person's name] lived, there was little happening to stimulate but here

there are things to do all the time." Another relative told us, "There is so much going on with youth clubs, sailing, discos, table tennis." We found that the activities programme had been in place for over a year and routinely rotated each week. Staff and managers offered a wide range of activities that people could choose to take part in; however, they had not built the activities programme around people's preferences. We did however see that people had enjoyed activities they took part in during the inspection. We spoke to the manager about the activities programme who acknowledged that improvements could be made to ensure people were involved in the development of the programme.

People were not able to share their views with us about how they would raise a complaint. We saw that surveys had been completed with people living at the service using a pictorial format although this was not recent. Relatives told us that they felt able to raise a complaint if this was needed. One relative told us, "If I don't like something or something is wrong it gets dealt with. I have never had to ask for something to be done or changed twice". The registered manager told us that they had only received one formal written complaint for this service. We saw this complaint and saw that the registered manager had provided an appropriate response in a timely manner. The registered manager explained to us that they only recorded formal written complaints and did not log any verbal or informal complaints that were made. They told us they would start to log all comments received to enable them to identify areas of improvement needed in the service.

Inadequate

Is the service well-led?

Our findings

We identified during the inspection that the provider had failed to submit statutory notifications regarding significant incidents that had arisen in the service. For example, we identified a number of safeguarding concerns that had arisen prior to the inspection that we had not been notified about. A statutory notification is a notice informing CQC of significant events and is required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents

The provider had failed to ensure that effective systems and processes were in place to identify and manage potential risks to people. We found multiple examples of failings by the provider to ensure that their management and staff team had identified and managed risks to people's health and well-being. We found that staff and management were not always aware of risks and hazards to people and therefore these risks had not been managed. Some of these risks were outlined in people's care plans and risk assessments and some were not. Where risks were recorded in care plans and risk assessments, managers and staff were not always aware that they had even been recorded. The provider had not developed systems to ensure that these risks were sufficiently understood by staff and therefore potential harm to people was not managed appropriately.

We found that care plans were not always reflective of people's care and support needs. The provider had not developed systems to ensure that the care and support people received met their needs. They had no system in place to ensure that reviews of care plans were effective and identified people's accurate support needs. They had no system in place to ensure that staff skills were sufficient to provide effective support to people. The provider had failed to ensure that people's care and support needs were known to staff. For example, the provider had failed to ensure that staff understood the needs of one person at risk of choking and asphyxiation. The provider had failed to ensure that the support provided met people's needs and kept them safe from harm.

We looked at the quality assurance processes that were in place and found that while some audits were completed, these were not effective at identifying the issues that we found during our inspection. We found that there was no internal medicines audit completed which had led to issues that we identified not being found and resolved. For example, we found that stock levels of medicines in the service did not match medicines records. We found that inadequate audits around care plans, risk assessments, accident and incident records meant that any issues or concerns with records or the care provided were not identified. Risks were not identified and therefore remedial action to manage the risks to people was not taken. The provider had failed to ensure that effective quality assurance systems were in place to manage risk and identify areas of improvement required within the service.

People and relatives had not been asked to share their views about the service recently. The registered manager confirmed that the last survey completed to obtain feedback from people and their families was in 2014. The registered manager confirmed that they were not recording informal feedback that was provided

to them about the service. Therefore there was no system in place to gather feedback in order to identify areas of improvement within the service. The provider had not ensured that the quality of the service was evaluated and improved.

The provider had failed to ensure that the management team responsible for running the service had the skills required to assess, monitor and manage the risks to people living at the service. We found that the acting deputy manager had received no management or leadership training. They had received no additional support from the provider despite them having less than six months experience in any managerial role. The registered manager and acting deputy manager had not received any training around developing risk assessments, which was an important issue that we identified during our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

We saw that staff members attended meetings with managers where information was shared about the service. Staff told us that they felt managers were supportive of them and were available if needed. Most relatives gave us positive views of the managers. One relative told us, "The current manager is so supportive and has been excellent." Another relative told us that things were improving and that they had had issues with staff not always knowing what was happening if the registered manager wasn't around. They hoped things would improve once the new deputy manager was settled in. Relatives and staff were mostly happy with the support and contact they received from managers.

We spoke to the management team about the issues that we identified during the inspection. We found that they did not fully understand how the inadequate leadership and management within the service had led to the issues that we found.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that notifications of significant events were submitted to CQC as required by law.

The enforcement action we took:

We have taken urgent action to cancel the registration of this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to inadequate risk management processes within the service. People were not protected from harm by the safe management of medicines.

The enforcement action we took:

We have taken urgent action to cancel the registration of this provider.

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 People were not protected by harm due to a failure to identify, report and management safeguarding incidents.

The enforcement action we took:

We have taken urgent action to cancel the registration of this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from harm due to inadequate governance, record keeping and quality assurance processes.

The enforcement action we took:

We have taken urgent action to cancel the registration of this provider.