CareQuality Commission

Leonard Cheshire Disability

The Regent

Inspection report

The Regent
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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 16 and 29 August and 26 September 2017. This inspection was announced. The provider was given notice of the inspection because they provide community services and we needed to be sure that someone would be in.

At our last inspection of The Regent, the service was compliant with the Regulations in force at that time.

The Regent provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The service provides support to people with physical or learning disabilities (aged 18 and above). The service operates 24 hours per day, seven days per week. At the time of our inspection there were nine people using this service, all of whom lived in their own flat.

There was a registered manager at the service. 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.

The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the Mental Capacity Act 2005. Staff had not been provided with appropriate training and therefore did not have the skills and knowledge required in order to support people safely. Quality assurance systems had not fully identified and addressed the impact on the wellbeing and continued safety of people who used the service.

People who used the service and their relatives told us that their support workers were friendly and caring. No one that we spoke with during the inspection, raised concerns about their support worker. However, people were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Most people had care plans and risk assessments in place, but these were not up to date and did not reflect current support needs or strategies to help staff manage risks appropriately. People had been involved in the development of their plans. However, they had not been provided with information or an explanation, in a way that they could understand as to why these documents were important.

There were limited opportunities for people to comment on the standard and quality of the service they received.

There were systems in place for people to raise concerns and complaints if they wished to. The people we spoke with were clear about who they would talk to about concerns. During our inspection no one raised

any major issues with us.

At this inspection we found seven breaches of the Regulations. These related to person centred care, consent, safeguarding people from abuse, safe care and treatment, dignity and respect, staff training and competency and the governance of the service.

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.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

The service had safeguarding procedures in place. Staff were not familiar with the processes to help keep people safe.

Risk assessments had been carried out but they were not up to date or centred on the needs of the individual person.

People's finances and medicines were not managed safely.

There were emergency plans in place for each individual who used this service. Organisational emergency plans were also in place to help ensure the continuity of service provision.

Is the service effective?

Inadequate

The service was not effective.

Support workers received some support, training and supervision with regards to their role and work but there were gaps in their skills and knowledge.

People who used the service were not always appropriately supported to make choices about their care needs and lifestyle.

The service did not have a good working knowledge of the key requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff who knew their preferences, needs and wishes.

Most of the staff spoke about the people they supported in a respectful manner.

People who used the service and their relatives told us that their support workers were caring and friendly.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had been involved in the development of their support plans. However, the plans were out of date and did not provide sufficient information to guide staff on people's current needs.

People were sometimes supported to access other health and social care services where necessary.

People who used the service received limited support to pursue their interests and maintain their social lives.

The service had a complaints process in place and the people we spoke to told us that they knew who to speak to if they were not happy.

Is the service well-led?

Inadequate

The service was not well led.

Care and support for people using the service was not always guided by good practice and management support.

The service had systems in place to help monitor and improve the quality of the service but these were not effective.

The organisation had policies and procedures in place but these were not consistently put into practice at this service.

Care Quality Commission

The Regent

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 checked 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 16 and 29 August and 26 September 2017. Follow up phone calls to relatives were made on 5 September 2017. The inspection was announced. We gave the provider 24 hours' notice because the location provides a Supported Living Service for younger adults who are often out during the day; we needed to be sure that someone would be in.

The inspection was carried out by two adult social care inspectors.

We gathered and reviewed the information we held about the service before the inspection. This included notifications; (notifications are changes, events or incidents the provider is legally obliged to send us within required timescales). We planned our inspection using this information.

We spoke to three of the people who used the service and received comments from seven of their relatives. We also spoke with six members of the staff team, including the registered manager. We contacted six health and social care professionals for their views on the services.

During our visit to the offices we reviewed the care records of five people who used the service. We reviewed the recruitment records of two members of staff and the supervision records of three members of staff. We also reviewed the training records of all the staff employed by the service.

We reviewed a sample of the policies and procedures in place at the service including safeguarding, lone working, complaints and compliments, behaviour support and intervention and management of medications.

We looked at the systems in place for the management and oversight of quality improvement and auditing of the service.

Inadequate

Is the service safe?

Our findings

We checked with the local authority adult social care team. They told us that they had not received any concerning information from the service. A social care professional said that the service notified them of incidents and concerns although they did not think they had been involved with any safeguarding investigations at this service. The information we held about the service indicated that there had been no safeguarding concerns. However, during our inspection we found some incidents that should have been reported to us and to the local safeguarding team.

The service had safeguarding processes and procedures in place. The staff we spoke to told us that they would report concerns to senior staff at the service, this included reporting colleagues displaying poor practices towards people using services (whistleblowing). However, they were not confident in recognising abusive practices. We found that managers were not clear about how they should handle allegations of abuse, including the need to report such matters to the relevant agencies. The deputy manager told us that staff training was out of date and that staff were not familiar with safeguarding. The deputy manager told us that she was in the process of sourcing some up to date training for all staff; "As there are only about two staff up to date."

We reviewed the way in which the service supported people with the management of their finances. The service had a policy and procedure in place regarding people's finances and possessions, but this had not been followed. Most people did not have full control of their finances and had not been supported to be as independent as possible with regards this. People's money had been kept in individual, locked cash boxes belonging to people who used this service. There were labelled keys to each cash box and an individual record of finances had been kept for each person. Balance checks had been carried out and receipts for purchases kept. No consideration had been given as to whether this practice was appropriate, the least restrictive or proportionate against the risks it sought to guard people from, or if it was in turn, institutional or financially abusive practice.

We asked the managers what the arrangements were should there be any discrepancies found in the cash boxes and balance sheets. The deputy manager stated that if it was a "few pence" staff had to replace this from their own money, "unless it is a lot." We asked the managers what they thought constituted "a lot" and at what stage they would consider reporting missing money as a safeguarding matter. We were told that £50 missing would be an appropriate level.

We were very concerned about the safe management of people's finances and following the inspection we referred the matter to Cumbria County Council's safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected from the risks of abuse and improper treatment because the provider did not operate effective systems and processes to prevent abuse and report allegations.

We reviewed a sample of people's individual risk assessments during our inspection. We found the information was lacking detail and did not provide accurate or up to date strategies and management plans to enable staff to support people safely. Some of the risk assessments that we reviewed were for people with very complex needs. They had been carried out by staff within the service. There was no evidence to support that the risk assessments had been approved by health and social care professionals, such as the community mental health team or social worker. Where people's needs had changed or an incident had occurred, risk assessments had not been routinely reviewed and updated to help staff manage situations in a positive way and mitigate risks. We found that there had been at least five recent serious incidents at the service where staff and people using the service had been harmed or placed at risk of harm. The incidents had not been reported to the relevant agencies. They had not been investigated or reviewed nor had action been taken to help prevent further occurrences. The lack of up to date risk assessments and management plans compromised the safety of the service and of people using it.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not done everything reasonably practicable to minimise and mitigate risks. This meant that people who used this service were placed at risk of receiving unsafe care and support.

We reviewed the way in which the service managed and supported people with their medication requirements.

The provider's medication policy stated that the service would work with individuals to develop or maintain the independence to participate in or manage self-administration where this was appropriate. At the time of our inspection there was no one managing their medicines totally independently. There was little evidence to confirm that people were encouraged and supported to manage their medicines in the least restrictive way. Medicines had been obtained on a monthly basis. One weeks' supply was stored in the person's own flat whilst the rest of their medicines were stored securely but communally in the offices of the service.

The deputy manager told us that staff required training or updates with regards to safe handling of medicines and that she was in the process of sourcing and arranging this type of training. The provider's medication policy stated that refresher training should be reviewed and updated annually. From the sample of staff training records we reviewed, we noted that most support staff had last received refresher training in 2015.

The sample of medication administration records (MARs) that we reviewed had not always been accurately completed. A list of people's prescribed creams and ointments were recorded on their MAR charts. However, they had not always been reflected in their support plans. This meant there was no guidance or instructions for staff to follow in order to ensure the correct use and application of this type of medicine. There were no clear instructions for the use of 'when required' (PRN) medicines. The instructions did not include the reasons when PRN medicines should be used or offered, the side effects of the medicine and guidance about monitoring the effectiveness of the medicine. The dosage to be administered was not clear. For example, one person had been prescribed Paracetamol, their PRN records stated '1 or 2 tablets' with no guidance as to the reasons for administering one tablet rather than two. There were no indications why this medicine should be used. The deputy manager made some amendments to PRN records whilst we were carrying out the inspection, but there were still gaps and lack of important information about the use of these types of medicines.

We found that one person had refused their medicines on at least two occasions. We asked the deputy manager about this. They told us that usually the GP would be contacted where people had refused two doses of their medicines. However, this procedure had not been followed on this occasion and the deputy

manager was unaware that medicines had been refused.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not have the skills and competence to ensure people were supported safely with their medicines.

People who used services told us that they knew who to speak to if they were worried or concerned about something. One person said; "If I was unhappy or concerned about something I would raise it with staff. I am not worried about raising concerns. The staff are very approachable and listen."

Another person said; "I can tell staff what I want support with, I think they help to keep me safe and I have some rules in place that help, particularly when I go out alone."

All the relatives we spoke with said they felt the service provided was safe. They told us risks to the individual person were assessed and, they "believed", carefully monitored. One person said, "[Person's name] is safe. I have no concerns." Another relative commented; "They (staff) have a good balance between allowing people to be independent and keeping them safe."

We reviewed the way in which support staff were recruited. We found that there were systems and procedures in place. Appropriate checks had been mostly carried out on prospective employees, including employment histories, personal profiles, references and criminal record checks (DBS). However, there was one file that did not contain all of the required checks. We discussed this with the registered manager at the time of the inspection. The registered manager took action to address this matter.

People who used the service told us that there were usually enough support workers to help them with their daily needs. They told us that the staff were mostly female. One person told us that they did not always know who their support worker would be and that they would prefer male carers to female carers because the females "tend to mother me". However, this person did not raise any concerns with us about the carers who supported them.

The service had appropriate emergency and contingency plans in place to help make sure the service could continue to operate in times of crisis. People who used the service also had personal emergency evacuation plans to help ensure they were supported safely to exit the building in an emergency. There were on-call systems in place so that staff and people who used the service could access advice or assistance at all times, including out of hours.

Inadequate

Is the service effective?

Our findings

The staff we spoke with told us that they had received training. One person said; "I think my training is up to date. I completed medication training about 18 months ago and I have supervision about every three to five months."

Staff told us that they were "wary" of some of the people who used the service, particularly around "moods" and "anxiety." Staff told us that the strategy for supporting people who may be anxious or in a "mood" was to go away and go back later to try to support them. One member of staff said; "(Name) sometimes has challenging behaviours or is verbally aggressive. If they get really anxious I would leave their flat. There are no plans other than this I've just picked it up and we just know (Name) really well. For example, if they paced the room this would indicate anxiety and I would not interfere then." Another member of staff told us; "I have had some MAPA training (Management of Actual or Potential Aggression) a while ago. It's ok doing this in training situation but different in real situations." MAPA training is designed to enable staff to safely disengage from situations that present risks to themselves, the person receiving care, or others, and helps people deal with aggression in a calm way that keeps everyone safe.

We looked at a sample of the staff supervision records. We found that supervision had not been carried out with any regularity, although staff told us that they felt supported. We looked at the staff training records and found that staff had not been provided with suitable training to help ensure their skills and knowledge were up to date and that they could support service users safely. There were particular gaps with regards to; safeguarding vulnerable adults, the Mental Capacity Act, supporting people who may have challenging behaviours, assisting people with their medicines and other specialist training such as autism, communication and supporting people with mental health needs. We reviewed the staff meeting minutes and found that staff had raised the matter regarding the need for this type of training and had identified that they were 'nervous' of one person in particular. The shortfall in this type of training had also been identified in the internal audit carried out in July 2017. A recommendation from the internal audit of the service, carried out by the provider, had been made that staff should receive this type of training as 'there are customers with challenging behaviours.'

We spoke to the registered manager about the arrangements with regards to staff training in behaviour support. The registered manager said that MAPA training was "not appropriate" and that they were looking at sourcing "Positive behaviour support training." The registered manager spoke about the "high cost" involved and that the training had to be "the right training."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not have the skills and competence to ensure they worked safely and that people who used the service were supported safely, particularly in times of crisis..

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. 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. We checked whether the service was working within the principles of the MCA. In community care settings applications to deprive people of their liberty must be made to the Court of Protection. At the time of our inspection no applications had been made, although there was at least one person at the service where this should have been considered.

One person who used the service told us that support staff always asked them for consent or permission prior to carrying out tasks or care. They told us; "They (staff) respect my wishes and I can refuse things if I want to. I am able to put my own point of view across."

Staff at the service had little understanding of consent or of the Mental Capacity Act 2005 or paid little regard to the principles of the Act and associated codes of practice. There were no best interests assessments or Mental Capacity assessments in place to confirm whether people had the capacity or were safe to manage aspects of their lives such as their own medicines or personal finances either with or without support. Despite this, the medicines and monies of most of the people who used this service were kept in a locked cupboard in the office of the service. This arrangement did not support the ethos of supported living schemes or of encouraging individual autonomy. The Mental Capacity Act states that people should be assumed to have capacity (until established otherwise) to manage their own lifestyles, including their finances and medicines. If these restrictive practices were in people's best interests, mental capacity assessments should have been carried out and recorded on their care files. Records around consent and capacity were incomplete and there was no clear indication that people understood and were happy to consent to these practices.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were not always appropriately supported to make choices about their care needs and lifestyle.

Most of the relatives spoken with felt the staff team had an acceptable level of knowledge and skills, and no one expressed any concerns about the levels of staff training. One relative said, "They seem to have regular training. They have had training in [person's name]'s health condition." A second relative commented, "The staff have the skills: they handle [person's name]'s behaviours well." Another relative told us the staff seemed properly qualified, and said they had no concerns in this area. A minority of relatives, however, felt that some care workers lacked the experience to deal appropriately with some challenging behaviours.

Where necessary, people were supported by their support workers to have a well-balanced diet, and to develop their independent skills in food preparation and cooking.

The relatives we spoke with told us that people's diet was monitored, and care plans were in place for those with particular dietary needs. Relatives were also happy with the attention paid to people's health issues, with evidence that people were referred to their GP or a specialist, where appropriate. Particular conditions such as epilepsy and diabetes were well-managed. One relative told us, "They keep a close eye on people's health."

Requires Improvement

Is the service caring?

Our findings

During our discussions with support workers, we found that they tried to adopt a caring approach and showed concern for people's independence, safety and well-being. However, their skills, knowledge and understanding of supporting people with complex needs were variable.

One of the staff we spoke with was very aware that people had differing needs and preferences. They said; "I try to encourage people to be more independent. Some days people need more motivation than other days. I try to find activities that are different and interesting but I also have to remember that people have their own needs and preferences." We asked another member of staff how they knew the care and support needs of one of the people they supported without a support plan. They told us. "Not sure, but we know (Name) well. Probably get the information at daily handovers and new staff would be told. I think there are some risk assessments in their file." The worker had little knowledge about what was recorded about this person and how to support and keep them safe.

People who used the service had limited involvement regarding the way in which the service operated. Tenants' meetings were not held and only one person told us that they had been asked for their views during a recent internal audit of the service.

During the inspection we observed negative responses from one of the managers at the service towards a person who used the service regarding their plans for paid employment. The dismissive response did not afford the person with dignity and respect, nor did it support the person with autonomy, independence and involvement in the community. We shared this information with the registered provider.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who use who use services must be treated with dignity and respect. People using the service must be provided with information and guidance about risks and benefits in a way they can understand. They must also be supported to express their views and be involved in decisions about the service and service provision.

Relatives described staff as being caring and friendly. One relative said, "They give hugs"; a second said, "They really look after [person's name]." A third relative told us, "The staff are very good listeners, you never feel hurried, and they are the same with [person's name]. Their approach to people is very good. They adjust to the person, and treat them with respect." Relatives felt staff worked hard to build up positive relations with people. One relative told us the service tried to match the personality of the worker with that of the person. Another relative said, "Staff take great care of [person's name], above and beyond anything I'd ever expected. They interact extremely well with [person]."

Relatives said people were treated with dignity and respect, were helped to maintain good personal hygiene and had their privacy respected. There were no concerns around confidentiality of personal information about people. Relatives also said they thought the service had a person-centred approach, and acted as advocates for people in meetings, where appropriate.

One of the people (male) who used the service told us: "I never know who my support worker is going to be. I would prefer to have a male carer rather than a female as they tend to mother me." We found that the service had limited access to male support workers and this restricted the preferences of people who used the service, particularly as the majority of people using this service were males. Another person said; "The staff help me but I'd rather help myself as some of them try to take over. I don't need them to do that." A third person told us; "The staff are very good and they are very punctual, they always let me know if they are going to be late for my visit. The staff have a passionate attitude towards their work and have helped me to become more independent. If it wasn't for them I wouldn't be here. A year ago I would never have thought that I would be living on my own."

People who used the service and their relatives were generally happy with the staff approach and relationships. However, we found that people were not always involved appropriately with their care and support options. Information and explanations had not always been provided. This was particularly with regards to essential records and documentation around support plans and managing risks. Some of the people who used the service had said that they did not want care records. The managers at the service had gone along with this instead of trying to provide appropriate explanations as to why such records were needed. The lack of such information meant that staff were not kept up to date with changes to people's needs and preferences.

Requires Improvement

Is the service responsive?

Our findings

We reviewed the care records of five people who used this service. Although we found that people had been involved in the development of their support plans, we found that these documents were out of date and inaccurate. Risk assessments and person centred plans in relation to people's support needs and safety had not been routinely reviewed and updated following incidents and accidents.

The registered manager told us of two people who had "chosen" not to have person centred plans. Brief records had been kept at the service and there was some evidence to support that these two people had been involved in the process. This meant that staff did not have up to date and accurate information as to how they should support people safely, nor would they be fully aware of the potential risks to themselves. The registered manager failed to understand the importance of developing clear care and support plans that reflected any risks, needs and preferences of people using the service.

We spoke with one of the people who used this service. They told us that staff let them stay in bed, that they asked staff to give them their medication and that staff went out and got cigarettes for them. They told us that they could suffer from 'low mood' and told us about the consequences of this. They thought that their support workers spotted the triggers to low mood and would "Check on me". We reviewed the care records of this person and their daily notes, which confirmed what they had told us. However, there was no evidence of encouragement or positive goal setting from staff to help motivate this person and help keep them safe. The staff we spoke to were also able to tell us about the behaviour triggers and the anxiety that this person sometimes suffered, but were not able to tell us what they would do. One member of staff we asked told us that they didn't really know what to do but wouldn't "interfere".

We saw that people had 'Hospital' Passports as part of the care and support plans. The aim of hospital passports is to assist people with disabilities to provide hospital and medical staff with important information about them and their health when they are admitted to hospital, for example. The passports are endorsed by the Department of Health and promoted by NHS England and are viewed as good practice. However, these lacked vital information about people' preferences, needs and behaviours, placing them and others at risk of harm and of not receiving the support they needed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have a care and support plan that was personalised specifically for them. This placed them at risk of receiving inappropriate and unsafe support.

Relatives told us they believed the service practised a person-centred approach to people's care. They told us they were able to be involved in the assessments of their relative's needs. Most relatives had at least some knowledge of people's care plans. One relative commented, "They follow [person's name]'s preferences and patterns, where possible." Another relative said, "The Regent is the ideal home for [person's name]. It definitely meets his needs." A third relative told us they worked together with staff on a behavioural management plan for their relative, and told us this was working well, and the person was more settled and stable now.

Other relatives said people's social lives were limited by a lack of staff and local resources, and also by the personality and behaviours of individual people. One relative said the lack of a garden at the service meant people were unable to get fresh air easily.

The registered manager told us that the service had not received any complaints. The service had a complaints process in place and the people we spoke to told us that they knew who to speak to if they were not happy. One of the people who used this service told us; "There were a few hiccups when I first moved in and a couple of times the call system didn't work. I have the phone number for the office now and if the system doesn't work it is usually fixed pretty quickly. I am not worried about raising concerns. The staff are approachable and I feel they listen to me."

Inadequate

Is the service well-led?

Our findings

Although we did not receive any adverse comments about the management of the service from people who used the service or from relatives, we found that the quality monitoring and auditing system in place at the service was ineffective. The systems in place had failed to identify that care records were out of date and were not reflective of people's current needs and risks. Risks to the health and safety of people using the service, staff and members of the public had been identified but not responded to appropriately or in a timely manner, particularly where people had complex support needs, including behaviours that could challenge and complex mental health needs. Information about people's support needs and any associated risks was out of date. Out of date information meant that the registered manager could not consistently maintain oversight of the safety at the service.

There was a registered manager at the service, who was in attendance throughout our inspection. The deputy manager was in day to day control of the service with some oversight by the registered manager. However, this oversight was limited and poorly maintained, partly because the registered manager was responsible for the management of other two other registered services, within the organisation. In addition to this, the registered manager told us that they were unaware that the Regulations applicable to registered providers had changed in March 2015. This meant that the registered manager was not clear about the fundamental standards, below which the care provided must not fall.

The majority of the risk assessments, audits and care plans had been completed by the deputy manager or the team leader. We reviewed the training records of the deputy manager and the team leader. They identified issues with much of their training, meaning that they did not have the appropriate skills and knowledge to effectively carry out their roles. This was reflected in the quality and accuracy of people's records, the restrictive and controlling practices around the management of people's finances and medicines.

Further evidence of an ineffective monitoring and auditing system was seen when we reviewed an internal audit that had been carried out in July 2017, by a Leonard Cheshire Disability auditor. They had failed to identify concerns about keeping people safe and the risks to the health, safety and well-being of people who used the service. However, their report had identified some areas for improvements, recommendations and actions. We reviewed the action plan that had been developed but deadlines had not been met regarding medication training, risk assessments and challenging behaviour training for staff.

We looked at the way in which medication audits had been carried out. The deputy manager told us that the team leaders carried out weekly audits of the medicines and that monthly audits were carried out too. We looked at the medication audits that were available. These showed that audits had not been carried out monthly. The audit records identified that staff frequently did not sign the medication administration records. However, the auditing records did not clearly identify whether it was the same person whose medication records were not accurate or whether it was the same member of staff not completing the records accurately. It was impossible to tell from the audit trail whether the medicines had actually been administered or that it was only that the signatures were missing. The deputy manager told us that the

organisation's medicines policy was for two members of staff to administer and sign for medications but that this did not always happen. We saw from the MAR charts at the time of our inspection, that they were frequently signed by only one person.

The deputy manager told us that they were confident that medicines had been administered as prescribed even though the administration records did not reflect this. There was no evidence to support that the shortfalls and poor practice identified by the audits had been followed up with staff to help improve their performance.

We spoke to the registered manager about the care plan auditing system. The registered manager said that care plan auditing had only recently become "part of the service manager's (registered manager) role and so far two care plans had been reviewed." They said that they "thought" each care plan was to be audited on an annual basis and that there was no set timescale for carrying out the audits.

The staff we spoke with during the inspection said that they felt supported by the managers at the service. One member of staff told us; "I can speak to the managers anytime. I think they listen and act on things I say. The staff team work together well too. We talk to each other and support each other as a team."

Staff meetings had been held, but not with any regularity. We reviewed the minutes of these meetings. Staff had raised issues about training, staff sickness, staff shortages and staff morale. Mixed opinions about the service performance had been recorded. We asked the registered manager if staff were able to comment on the quality of the service. We were told that they had been involved in quality assurance surveys but the response had been poor nationally, and there was no report available.

The service had policies and procedures in place designed to help ensure the safe and effective operation of the service. However, we found that many of these processes had not been followed in practice nor had there been any assessments or reviews carried out to check that staff understood and followed them. Staff training was out of date and they had not been provided with appropriate training and competency checks to help make sure they worked safely and kept people safe.

Safeguarding matters, accidents and incidents had not been referred to the appropriate agencies, including the local authority and the Commission as necessary. Such incidents had not been reviewed internally in order to introduce measures to reduce or remove the risks for people using, working or visiting the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems to assess, monitor and improve the quality of the service were not effectively operated. This place the health, safety and welfare of people who used the service and others at risk.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used this service did not have a care and support plan that was personalised specifically for them. This placed them at risk of receiving inappropriate and unsafe support. Regulation 9(1)(3)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who use services were not always treated with dignity and respect because they were not provided with the support they needed to be autonomous and independent. Regulation 10(1)(2)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done everything reasonably practicable to minimise and mitigate risks. This meant that people who used this service were placed at risk of receiving unsafe care and support. Staff did not have the skills and competence to ensure people were supported safely with their medicines. Regulation 12(1)(2)(a)(b)(c)(g)(i)

Regulated activity	Regulation

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used this service were not protected from the risks of abuse and improper treatment because the provider did not operate effective systems and processes to prevent abuse and report allegations. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality of the service were not effectively operated. This place the health, safety and welfare of people who used the service and others at risk. Regulation 17(1)(2)

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service were not always appropriately supported to make choices about their care needs and lifestyle. Regulation 11

The enforcement action we took:

We issued an urgent notice of decision to apply some conditions to the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the skills and competence to ensure they worked safely and that people who used the service were supported safely.

The enforcement action we took:

We issued an urgent notice of decision to apply some conditions to the provider's registration.