Care Quality Commission

Richmond Fellowship(The)

Windsor Road Mental Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place across two dates 16 and 30 November 2015. The first day of inspection was unannounced.

The last inspection of Windsor Road Mental Nursing Home was 03, 04, 08, 09 and 16 June 2015. At that time we found concerns in arrangements to safeguard people against the risk of abuse, safe care and treatment, staff training and support. The procedures for obtaining valid consent, care planning and risk assessment were not robust, and we had concerns regarding staffing and the systems in place to monitor and check the quality of the service provided.

These concerns were found to have a major impact on the welfare and safety of people who lived at the service.

As a result of our findings we commenced enforcement action against the provider. They were issued with a

Summary of findings

notice of proposal to remove conditions from their registration for failing to meet the requirements of regulations 9, 10, 11, 12, 13, 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service was Inadequate and the service was placed into special measures.

During this inspection we reviewed actions taken by the provider to achieve compliance with the notice of proposal issued to the service following the previous inspection in June 2015.

We found that some improvements had been made. These were linked to environment safety, person centred mental health recovery work, staffing and quality assurance.

Windsor Road Mental Nursing Home as a condition of its registration should have a registered manager in place. 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 new manager who had commenced post in October 2015. An application had been submitted for the manager to become registered with the Care Quality Commission and this was being processed.

Windsor Road Mental Nursing Home provides care and accommodation for up to eleven adults who have enduring mental health needs. The home is a purpose built establishment with facilities on two levels, the upper floor being served by a passenger lift. All accommodation is offered on a single room basis including self-contained bedsit type facilities with private kitchen areas. The home is located on a quiet road in Lytham St Anne's close to local amenities and bus routes.

There were eight people who lived at the service at the time of the inspection.

People told us that they felt safe living at Windsor Road Mental Nursing Home. One person told us "I am happy here, everyone is happy here".

We looked at four people's care records. We found that incidents where people had attempted to take their own life or cause significant injury to themselves had not been referred to the safe guarding authorities.

It is clearly outlined in the Health and Social Care Act 2014 that acts of self-neglect are reportable to local safeguarding authorities. This meant that the service had failed to follow clearly defined safeguarding adults at risk procedures.

We pathway tracked four people who lived at the service and looked at how the service managed the risks associated with their care and welfare.

We found that two out of four people we pathway tracked had not been effectively risk assessed or protected against the risk of self-injury and attempt to take their lives. Significant incidents had occurred on a frequent basis and the service had failed to undertake comprehensive risk assessments to formally assess, monitor and prevent self-injury and suicide attempts. Therefore we judged the impact for people who lived at the service with such needs to be a major risk.

We found that the service had improved on accident and incident reporting. Communication internally and externally with health and social care professionals had greatly improved. This meant that risks to individuals were being assessed by the team on a more frequent basis.

We looked at the way the service managed people's medicines. We found that medicine ordering systems were not robust, therefore placing people at high risk of not receiving their medicines as prescribed. However we found no instances where people had gone without their medicines.

Medicine ordering systems were chaotic and the service did not have a sufficient ordering schedule: this meant that people's medicines were not always ordered in time. We found examples of people's medicines running out and an emergency prescriptions being requested. A lack of stock control placed people at high risk of not receiving their medicines as prescribed.

We observed safe administration of medicines during the inspection.

Summary of findings

We looked at the standard of safety in people's bedrooms. We found that rooms were free from fire risks and clean.

Significant investment had been made at the service to improve the standard of environment. Compliance with health and safety regulations had been achieved and the service had worked in partnership with people who lived at the service to implement a no smoking policy that was due to commence 01 December 2015.

We looked at staffing rotas and found that the manager had good oversight of staffing at the service. The service had an agreement with health commissioners to send weekly updates of staffing levels at the service to ensure that contractual agreements were being met.

We received positive feedback from people who lived at the service regarding the support they received and we did not receive any concerns about staffing levels.

We looked at training records and found that courses identified at the last inspection as not being completed had been planned and undertaken by most staff. These included safeguarding adults, Mental Capacity Act 2005, fire training, medicine management including competency assessments for administration of medicines and health and safety.

We found that the service had not considered training for staff around known risks to individuals at the service. For example instances of self-injury and attempt of suicide. The provider had not arranged suitable training for staff to ensure that they were competent in understanding how to deal with these risk factors. We discussed this with the manager during the inspection and immediate actions were taken to obtain training.

We asked staff if they felt supported. All staff we spoke with confirmed that they were supported in their role and understood their responsibilities.

We looked at the provider's policy and procedures around the Mental Capacity Act 2005. We found that new documents had been created since the last inspection to encourage engagement from people's care co-ordinators when assessing a person's mental capacity [if required]prior to admission. We looked at mental capacity assessment documents and found that the service had made necessary improvements to enable compliance with principles outlined in the Mental Capacity Act code of conduct.

During this inspection we looked at four people's care records and found that effective communication had been maintained with involved health and social care professionals.

We looked at how the service helped people maintain a balanced diet. We found that people were actively engaged in and independently cooked their meals. We observed people who lived at the service access the main kitchen area and they told us "Yes I have all the food I need". And "I like the freedom to cook what I like".

We noticed that the level of engagement with people who lived at the service had improved. Staff told us "It is more positive than it has ever been to work here". And "The best thing about working here is the sense of achievement when we have got something done with a client and staff work together to achieve people's goals".

We looked at four people's care records. We found that people were encouraged to participate in the creation and review of their own support plans. We saw that people received regular one to one time with their key workers. People who lived at the service told us that this was a great improvement.

From the four care plans we looked at, we found that many support plans had been written in a person centred way, with involvement from the individual. For example we saw people's recovery goals and aspirations had been recorded. We also saw that people's life stories were referenced in care records and people had been provided with an opportunity to say what they wanted their care plan to involve.

We saw reference in people's care records regarding 'moving on'. One person told us that the service had helped them fight for a place at a service that would be beneficial for their recovery.

People told us that they felt confident to raise their concerns. We asked to look at complaints and the compliments receivedsince the last inspection in June 2015. The nominated individual told us that no complaints or compliments had been received.

Summary of findings

We looked at staff meeting minutes and found that the provider had developed regular opportunities for staff to attend meetings and express their views. We found that meeting agendas were positive. This was an improvement since the last inspection.

We found that the service had systems in place to assess, monitor and evaluate the quality of care and support. We found that quality assurance was in place and action was taken when issues had been identified.

Audits were in place for medicines, recruitment, health and safety, training and care records.

We looked at the medicines audit and found that issues identified at this inspection had not been highlighted. We discussed this with the new manager who reassured us that robust management oversight would be undertaken.

We found that the provider was still in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safeguarding and safe care and treatment.

The overall rating for this service is 'Requires Improvement'. However, we are keeping the service in 'Special Measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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.

Summary of findings

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 safe was not consistently safe.

We found that the service did not always inform safeguarding authorities when a person placed themselves at risk.

We found that the risks associated with people's care and support were not always sufficiently assessed.

Environment safety had improved. The service undertook regular checks of environment safety and acted upon concerns.

The service deployed sufficient numbers of staff to meet people's assessed needs.

We found that medicines management systems were not robust and placed people at risk of not receiving their medicines as prescribed.

Is the service effective?

Requires improvement

The service had made improvements around effective care. These changes now need to be continued and sustained.

We found that most staff had received training inline with the providers expected mandatory courses. Training had been planned.

We found that the provider had not been responsive to high risk issues, and that staff had not received the required training beyond their mandatory courses.

The service had implemented new ways of working to ensure that a person's consent was sought inline with principles of the Mental Capacity Act 2005.

People were effectively supported to maintain a healthy diet and had access to on going healthcare support.

Is the service caring?

Requires improvement

The service was caring.

We found that positive relationships had been made between people who lived at the service and staff.

People were encouraged to participate in making decisions about their care, treatment and support.

We observed kind support interventions and found that people's dignity was respected.

Summary of findings

Is the service responsive?

Requires improvement

The service had made improvements around responsiveness. These changes now need to be continued and sustained.

We found that people's care plans held person centred information and detail for staff to follow. However, the service did not always effectively risk assess people's individual needs, therefore improvements were required around the provision of person centred support.

People told us that they felt listened to and we found that regular key worker meetings have improved the level of communication and support for people who lived at the service.

The service had a comprehensive complaint procedure in place. No complaints or compliments have been received since our last inspection.

Is the service well-led?

Requires improvement

The service had made improvements around quality assurance and leadership that now need to be continued and sustained.

We found that the provider had implemented a good standard of management oversight at the service.

There was a new manager who showed an understanding of improvements needed and was able to demonstrate pro-active responses to our concerns as well as partnership working.

Quality assurance audits were in place and issues identified were actioned.

Windsor Road Mental Nursing Home

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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of service, and to provide a rating under the Care Act 2014.

This inspection took place on 16 and 30 November 2015. The first day of the inspection was unannounced. The inspection team consisted of three adult social care inspectors and a specialist advisor for medicine management.

Before the inspection we reviewed information from our own systems which included notifications from the provider, safeguarding alerts and two whistle blowing concerns. In particular, information we had received since our last inspection in June 2015.

We reviewed the content of the notice of proposal to remove conditions from the providers registration for failing to meet the requirements of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was issued to the provider following the previous inspection in June 2015. The overall rating for this service was Inadequate,and the service was placed into special measures.

We gained feedback from an external health and social care professional who had contact with the service on a regular basis. As part of this we were provided with auditing information undertaken by the local Clinical Commissioning Group [CCG] [CSU] and have received regular updates from the associated professionals.

We spent time talking with people who lived at the service, reviewed records and management systems and also undertook observations of support being provided at the service.

We spoke with six people who lived at the service, the nominated individual, manager, team leader, two registered Nurses and five assistant recovery workers.

We looked at four people's care records, staff duty rosters, four recruitment files, management audits, medication records and quality assurance documents.

Inadequate

Is the service safe?

Our findings

During our last inspection of the service we found significant short falls regarding procedures for keeping people safe.

We found ineffective systems around safeguarding, managing risks to individuals, medicines management, staffing and premises safety.

We deemed this to have had a major impact on people who lived at the service. As a result of our findings we started enforcement action against the provider who was issued with a notice of proposal to remove the conditions from the provider's registration for failing to meet the requirements of regulations 12,13,15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the notice of proposal issued following inspection of the service in June 2015.

People told us that they felt safe living at Windsor Road Mental Nursing Home. One person told us "I am happy here, everyone is happy here".

We looked at four people's care records. We found that incidents were people had attempted to take their own life or cause significant injury to themselves had not been referred to safe guarding authorities.

Records showed that people had been escorted to secondary care services in most instances, such as accident and emergency or mental health assessment units. We found that communication with people's care co-ordinators [care co-ordinators are mental health practitioners assigned to support people living with mental health needs] had vastly improved.

However it is clearly outlined in the Care Act 2014 that acts of self-neglect are reportable to local safeguarding authorities. This meant that the service had failed to report under grounds of safeguarding adults.

We looked at the providers quality review audit tool undertaken on 22 October 2015. The audit showed instances in August and September 2015 when a person who lived at the service had reported to staff that they had been subjected to threatening behaviour from a family member and financial abuse. The audit shows that safeguarding referrals had not been made to the local safeguarding authority. The service had made contact with the person's care coordinator.

These shortfalls in safeguarding amounted to a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff training records and found that all staff had received training in safeguarding adults. After the inspection we were informed by local commissioners that the provider was working in partnership with mental health commissioning teams and had sought extra support from safeguarding leads within the health authority to establish best ways in working around safeguarding adults.

We looked at four people's care records. We found that two people had not been effectively risk assessed or protected against self-injury and attempt to take their lives. Significant incidents had occurred on a frequent basis and the service had failed to undertake comprehensive risk assessments to formally assess, monitor and prevent self-injury and suicide attempts. Therefore we judged the impact for people who lived at the service with such needs to be major.

Shortfalls in risk management amounted to a breach of regulation 12 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service had improved on accident and incident reporting. Communication internally and externally with health and social care professionals had greatly improved. This meant that risks to individuals were being assessed by the team on a more frequent basis.

We looked at protection plans for two other people who lived at the service and found that a good standard of risk assessment had been undertaken.

We asked people who lived at the service if they felt safe and able to approach staff should they be unwell or concerned. People told us that they were supported and some people used a verbal code with staff that would indicate when they needed support urgently. We found an improvement in the level of individualised support people received.

We asked staff if they felt confident in their roles to risk assess and effectively support people with complex mental health needs. Staff told us “Sometimes we are just fire

Inadequate

Is the service safe?

fighting the risks with some people that live here". "Clients have got more difficult to work with and we are struggling with the risks with some people". And "Keyworkers do not update the care plans the nurses do this, things aren't always updated as they should be and there is room for improvement".

We looked at how the service managed people's medicines.

We examined medicine administration records and medicine care planning for six people who lived at the service. We found that medicine ordering systems were not robust, therefore placing people at high risk of not receiving their medicines as prescribed. However we found no instances where people had gone without their medicines.

Ordering systems were chaotic and the service did not have a sufficient ordering schedule that meant people's medicines were in line with monthly medicine administration records. We found examples of people's medicines running out and an emergency prescriptions being requested. A lack of stock control placed people at high risk of not receiving their medicines as prescribed.

We found gaps in medicine administration records where medicines had not been signed for. It is important that records about medicines administration are accurate to demonstrate that people are given their medicines as prescribed.

One person was prescribed a controlled drug. On one occasion this had been administrered a day late.Care records showed that no entry had been made to explain why this had occurred.The manager told us that they had not been made aware of this incident. The person did not appear to suffer any ill- effects of this late administration.

Staff maintained a running balance of medicines on the medicine administration record and night staff carried out weekly checks of stock balances. However on the day of inspection we found that the quantity recorded did not always balance with the actual stock held at the service.

We found examples where the stock balance did correlate but the medicine administration record count appeared to have been written over. Sometimes this was illegible and it was difficult to confirm an accurate audit trail of medicines.

In some cases it was also difficult to undertake an audit check as medicines had not been accurately carried forward at the start of the new cycle or booked in clearly.

We looked at people's care plans and found that information about people's medicines that they were prescribed on a 'when required' basis was poor. We discussed this with the team leader who was accountable for medicines management and they agreed to look at improved ways to record people's needs around medicines that should be taken when required.

These shortfalls in medicines management amounted to a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed safety of the premises, including the use of equipment. We found that the standard of safety in people's bedrooms had significantly improved. We found that rooms were free from fire risks and clean.

Significant investment had been made at the service to improve the standard of environment. Compliance with health and safety regulations had been achieved and the service had worked in partnership with people who lived at the service to implement a no smoking policy that was due to commence 01 December 2015.

People who lived at the service told us "Will be better with no smoking inside, will get fresh air and mix with others". And "The environment is much better".

Prior to this inspection we received whistleblowing concerns about low staffing levels and subsequently the lack of support people who lived at the service received. We raised a safeguarding alert to the local safeguarding authority who took precedence in investigating such concerns.

We looked at staffing rotas and found that the manager had good oversight of staffing at the service. The service had an agreement with health commissioners to send weekly updates of staffing at the service to ensure that contractual agreements were being met.

We received positive feedback from people who lived at the service regarding the support they received and we did not receive any concerns about staffing levels.

Inadequate

Is the service safe?

During the inspection staff did not raise concern about staffing levels. Staff told us "Staff are stepping up now, probably due to management change". And "Staff try really hard to help people achieve what they want to".

The manager told us that staffing levels had been assessed in line with dependency levels of people who lived at the service, and that staffing levels were under continual review. The manager also told us that they had recruited registered nurses and assistant recovery workers in line with contracted hours at the service. This meant that a consistent approach to recovery support could be adopted.

We looked at recruitment processes and found that the provider had maintained safe systems during employment of new staff. We looked at two new starters personal files and found that pre-employment checks had been made. We did not see evidence of probation reviews for the new starters; however they had received supervision since being appointed.

Requires improvement

Is the service effective?

Our findings

During our last inspection of the service we found short falls regarding procedures for ensuring people who lived at the service received effective care.

We found that staff had not been provided with necessary training to ensure that people who lived at the service received effective care that was based on best practice. We also found that the service did not have robust systems in place to ensure that people received care inline with principles of the Mental Capacity Act 2005.

We deemed this to have had a major impact on people who lived at the service. As a result of our findings we started enforcement action against the provider who was issued with a notice of proposal to remove the conditions from the providers registration for failing to meet the requirements of regulation 18 &11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the notice of proposal issued following inspection of the service in June 2015.

We looked at training records and found that courses identified at the last inspection as not being completed had been planned and undertaken by most staff. These included safeguarding adults, Mental Capacity Act 2005, fire training, medicine management including competency assessments for administration of medicines and health and safety.

We previously identified that staff had not received training in understanding mental health recovery and management of behaviours that challenge; inclusive of self-defence. We found that 8 out of 14 full time employed staff had received management of actual or potential aggression [MAPA] training. And six staff had attended training in mental health recovery. The service had a training plan for 2015/ 2016 that showed on-going training arrangements.

We found that the service had not considered training for staff around known risks at the service. For example instances of self-injury and attempt of suicide were reported about on a frequent basis. The provider had not arranged suitable training for staff to ensure that they were competent in understanding how to deal with these risk factors. We discussed this with the manager during the inspection and immediate actions were taken to obtain training.

We looked at staff supervision records and found that regular opportunities for staff to have one to one meetings with their line manager were undertaken in line with the providers expectations. Supervision content was clear and supportive.

We asked staff if they felt supported. All staff we spoke with confirmed that they were supported in their role and understood their responsibilities.

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 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the providers policy and procedures around the Mental Capacity Act 2005 and found that new documents had been created since the last inspection to encourage engagement from people's care co-ordinators when assessing a person's mental capacity [if required] prior to admission. We looked at mental capacity assessment documents and found that the service had made necessary improvements to enable compliance with principles outlined in the Mental Capacity Act code of conduct.

We discussed the need to embed these procedures at the service with the manager and nominated individual and it was agreed that this was on going.

We looked at four people's care records and found that effective communication had been maintained with

Requires improvement

Is the service effective?

involved health and social care professionals. For example one person was repeatedly placing themselves at risk. Care records showed that this information was passed onto involved mental health professionals.

The manager told us that they had started to chair scheduled meetings with people's care coordinators when this was possible. This measure was put into place to ensure that effective information sharing was sustained.

We looked at how the service helped people maintain a balanced diet. We found that people were actively engaged in and independently cooked their meals. We observed people who lived at the service access the main kitchen area and they told us "Yes I have all the food I need". And "I like the freedom to cook what I like".

People who lived at the service did not have any specific dietary needs. It was positive to observe people being supported to maintain their cooking skills and we saw people gain enjoyment from this daily activity. We visited people in their bedrooms. One person showed us their kitchen area, a hygienic environment had been maintained.

Requires improvement

Is the service caring?

Our findings

During our last inspection of the service we found that people's dignity was not always considered.

We deemed this to have had a moderate impact on people who lived at the service. As a result of our findings we started enforcement action against the provider who was issued with a notice of proposal to remove the conditions from the providers registration for failing to meet the requirements of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the notice of proposal issued following inspection of the service in June 2015.

People who lived at the service told us "The support is very good". "I am happy here I can come and go as I please". And "Yes everyone is nice I have no concerns". "I am treated well".

We observed staff interact with people who lived at the service across both days of inspection. We saw trusting relationships had been built and pleasant conversation between people who lived at the service and assistant recovery workers appeared natural.

We noticed that the level of engagement with people who lived at the service had improved. Staff told us "It is more positive than it has ever been to work here". And "The best thing about working here is the sense of achievement when we have got something done with a client and staff work together to achieve people's goals".

We looked at four people's care records. We found that people were encouraged to participate in creation and review of support plans. We saw that people received regular one to one time with their key workers. People who lived at the service told us that this was a great improvement.

We received feedback from an external health care professional who monitored the service in line with commissioning and contractual agreements. Positive feedback regarding improvements made at the service around involvement was received.

We looked at monthly meeting minutes held with people who lived at the service. Minutes showed a good standard of involvement. It was positive to see that the service actively engaged people in decision making. For example decisions about decoration, choosing furniture and planning holidays.

We observed staff maintain and protect people's dignity. Staff approached people who lived at the service in a kind and sensitive way. We observed staff ask for permission to enter people's private spaces.

We found improvements around maintaining people's wellbeing and therefore protection of people's dignity had been achieved. The manager told us that improved systems need to be sustained and continual review and feedback will be sought.

During feedback we asked the manager and nominated individual if consideration had been made regarding the registered name for the service. We acknowledged that the registered name was not advertised outside the service, however it was agreed that the title of Windsor Road Mental Nursing Home was not particularly dignified in the sense of maintaining people's person hood.

We have advised the provider how to proceed should the service wish to change its registered name.

Requires improvement

Is the service responsive?

Our findings

During our last inspection of the service we found person centred care was not always considered.

We found that people had not always been protected against known risks and a person centred care plan had not been developed which placed people at significant risk of deterioration in their mental health and wellbeing.

We deemed this to have had a major impact on people who lived at the service. As a result of our findings we started enforcement action against the provider who was issued with a notice of proposal to remove the conditions from the providers registration for failing to meet the requirements of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the notice of proposal issued following inspection of the service in June 2015.

We asked people if they felt the service was responsive to their needs. People told us "Yes I have made progress. I am planning on starting voluntary work". "I feel more positive about life recently". And "The one to one meetings are great, it gives me time to discuss what I want to do and how I will move on".

We looked at four people's care records. We found that many support plans had been written in a person centred way, with involvement from the individual. For example we saw people's recovery goals and aspirations had been recorded. We also saw that people's life stories were referenced in care records and people had been provided with an opportunity to say what they wanted their care plan to involve.

We found gaps in recognising and managing associated risk for individuals as we have reported in the safe domain of this report. This meant that for two of the people who we pathway tracked, person centred care planning had not been developed effectively. However we discussed this with the manager and nominated individual during the inspection and actions were put into place to review these people's needs immediately.

We found that recovery work at the service had improved. Some staff had obtained training around what mental health recovery means and we could see that people were being encouraged to lead an independent life style.

The service had started to look at how it could improve as a short stay recovery and enablement service. The new manager told us that they were keen to address expectations with people who lived at the service and when people were admitted to hospital more thorough assessments were going to be undertaken prior to the service accepting people back to the service without considering the potential impact on other service users and staff.

We saw reference in people's care records for moving on. One person told us that the service had helped them fight for a place at a service that would be beneficial for their recovery.

We found that the service had started to encourage people to access community activities. People told us that they were looking forward to starting voluntary work and attending college to gain qualifications.

People told us that they felt confident to raise their concerns. We asked to look at complaints and compliments since the last inspection in June 2015. The nominated individual told us that no complaints or compliments had been received.

People who lived at the service had access to the complaints procedure. The provider had a comprehensive complaints policy and procedure that was accessible for all staff.

Requires improvement

Is the service well-led?

Our findings

During our last inspection of the service we found that the service was not well led.

We found that quality assurance systems were not in place to ensure that people received safe and effective care.

We deemed this to have had a major impact on people who lived at the service. As a result of our findings we started enforcement action against the provider who was issued with a notice of proposal to remove the conditions from the providers registration for failing to meet the requirements of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed requirements outlined in the notice of proposal issued following inspection of the service in June 2015.

People who lived at the service told us that they felt confident to approach the management team. We observed interactions between the staff team and people who lived at the service and found that people appeared relaxed and open in their communications.

At the last inspection we found a poor culture throughout the staff team had a negative impact on people who lived at the service. We asked staff if they felt that the culture at the service had improved. We received mixed feedback.

Staff told us "Staff morale is good, everyone pulls together". "It's more positive than ever". "Staff morale is quite low". And "We find some of the behaviours of people living here challenging, this can get the team down".

We looked at staff meeting minutes and found that the provider had developed regular opportunities for staff to attend meetings and express their views. We found that meeting agendas were positive. This was an improvement since the last inspection.

We asked staff if they were given the opportunity to debrief after significant events at the service. For example when a person had self-injured. Staff told us that handovers were thorough and provided time for discussion including lessons to be learnt. The manager agreed that more structured group supervisions would benefit the staff team following exposure to significant events.

We found that the service had systems in place to assess, monitor and evaluate the quality of care and support. We found that quality assurance was in place and action was taken when issues had been identified.

Audits were in place for medicines, recruitment, health and safety, training and care records.

We looked at the medicines audit and found that issues identified at this inspection had not been highlighted. We discussed this with the new manager who reassured us that robust management oversight would be undertaken.

We looked at a quality assurance audit undertaken by the central quality team within the organisation. We found that a detailed audit of the service had been undertaken in July and October 2015 and action planning had been formulated and reviewed.

The provider submitted an action plan that addressed non-compliance with the Health and Social Care Act 2014 regulations, the provider had maintained continual review of the action plan and updated us on a regular basis.

The provider had worked in line with requirements set by health commissioners and also submitted regular action plan updates. We received feedback from an external professional who told us that the provider had worked in partnership with them to improve the level of care provision at the service.

A new manager had been appointed in October 2015. We found that the manager was aware of areas for improvement and worked in partnership with us throughout the inspection. The manager was pro-active at addressing our concerns.

We found that the service was being led by a strong management team who understood how to prioritise and move forward. This meant that the level of risk identified at the last inspection around lack of quality assurance had been reduced due to effective communication and planning.

We discussed the need to sustain improvements made around quality assurance with the manager. The manager agreed that continued development around oversight at the service was needed to ensure that improvements could be sustained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **When people had ether placed themselves at risk of self-harm or self-injury the provider had not always made a safeguarding referral to local safeguarding authorities.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not implemented proper and robust systems to make sure that care and treatment was provided in a safe way for service users.** Regulation 12 (1) (2) (a) (b) (c) (g).

The enforcement action we took:
This provider is in special measures. This inspection found that there was not enough improvement to take the provider out of special measures.
CQC is now considering the appropriate regulatory response to resolve the problems we found.