Cumbria County Council

Cavendish House

Inspection report

Elizabeth Street
Workington
Cumbria
CA14 4DA

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23 March 2016
04 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

We carried out an unannounced comprehensive inspection of Cavendish House on 19 & 23 March and 4 & 13 April 2016 at which multiple of breaches of legal requirements were found. The Care Quality Commission found evidence that people were being exposed to harm or the serious risk of harm.

Cavendish House is a service provided by Cumbria County Council. The service provides short-term respite accommodation for up to six people who have a learning disability and/or a physical disability. Two places available were for emergency admissions. The house is situated near the centre of Workington in a residential area. Accommodation is in single rooms.

The home had a registered manager who had applied to remove her registration but was continuing to be registered for other services for Cumbria County Council. 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 and associated Regulations about how the service is run.

Staff had been trained in the protection of vulnerable adults but were not always identifying and reporting potential abuse appropriately. Some people were not being protected from potential or actual abuse and improper treatment.

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

Risk assessments relating to the health, safety and welfare of people had not always been completed and did not include plans for managing and mitigating risk.

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

The premises were not secure and not suitable for providing short stay and emergency placements. The building and equipment were not being routinely cleaned or maintained to a good level. There were problems with infection control.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deployment of staff and staffing levels at the service did not ensure that people's needs could be met. People were spending long periods of time with little or no staff interaction. Staff had received training relevant to their roles. However, we found that staff were not always putting this training into practice. Staff supervisions and team meetings were mostly up to date. However, the nominated 'manager' had not

received supervision for several months. The registered manager who was legally responsible for the service did not supervise staff and was not based in the home.

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

Cumbria County Council had suitable recruitment and disciplinary procedures in place.

Medicines were managed appropriately.

Communication in the service was inconsistent between staff and between shift changes. Staff were not always up to date with the support people needed.

We had evidence of unlawful practices under the Mental Capacity Act 2005 in terms of a failure to obtain lawful consent.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff prepared suitable meals and snacks for people but nutritional planning was not always in place. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment, both inside and out, needed to be developed and refurbished. There were no plans to upgrade the building available during the inspection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not ensured that the premises was fit for purpose and took into account national best practice.

We saw caring and positive interactions from staff who helped people to maintain their privacy and dignity. Staff had an understanding of the needs of people in the service but were not always guided to help people to maintain or improve their independent living skills. We made a recommendation about developing independence and promoting well-being.

Assessment and care planning did not identify all the health and social care needs of people. Care plans were not updated and reviewed after significant or serious events or when needs changed.

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

Activities and entertainments were not been developed to meet people's needs. We saw that people were isolated in the service, particularly in the evenings and at weekends.

This was a breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager who did not line manage staff and had no control over resources. The service had not had consistent leadership for some time.

The provider had failed to notify the Care Quality Commission of safeguarding matters and other matters of concern. This was a breach of Regulation 18 of the (Registration) Regulations 2009 by Cumbria County Council or the Registered Manager. This was a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

Cumbria County Council's quality assurance system had failed to identify all of the problematic issues in the home. Some problems had been identified but no action taken. There was a failure of governance and oversight by the provider, Cumbria County Council.

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

We served a notice of decision to prevent admission to this service. The Provider complied with this condition and the home now has no one in residence.

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.

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.

Risks were not appropriately managed and potential safeguarding matters were not well managed.

Staffing levels did not meet the assessed needs of the people in the home.

Infection control measures in the home were not robust and people living and working in the home were put at risk of infection.

Is the service effective?

Inadequate

The service was not effective.

Staff working in the home had not received regular supervision, support or leadership to make sure they were competent to provide the support people needed.

Where people were being deprived of their liberty suitable lawful authority had not been sought.

The building was not fit for purpose, being part of an office block which compromised safety and privacy.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff to be caring and kind.

The delivery of care and services did not always take the well-being of individuals into account.

Independence was not promoted in the service.

Is the service responsive?

Inadequate

The service was not always responsive.

Assessments and care plans were not in enough detail and were not always updated when a person's need changed.

Activities and entertainments were limited and did not encourage community involvement.

Is the service well-led?

Inadequate

The service was not well led.

The home lacked leadership because suitable management arrangements were not in place.

The quality monitoring systems in place had not identified all of the problems in the service.

The provider had not taken sufficient steps to deal with the failures of leadership, safeguarding, care delivery, staffing and the environment.

Cavendish House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was the first inspection of this service since Cumbria County Council re registered in October 2015. Prior to this the registered provider was registered as Cumbria Care which is part of the County Council. The last inspection of the service was in September 2015 when we rated the service as Good. Cavendish House is situated within walking distance of the town. The service provides six places for people living with a learning or physical disability. Two of these places are used for emergency admissions. The accommodation is in single rooms.

An adult social care inspector conducted an unannounced inspection on Saturday 19 March 2016. A number of breaches and concerns were found at the inspection and a follow up visit with another adult social care inspector was carried out on 23 March 2016. On 4 and 13 April 2016 the lead inspector visited the service again because of our concerns about the safety and well-being of individuals in the service.

Prior to our visits the service had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We planned the inspection using this information. Before our inspection we reviewed the information we held about the service. We contacted the local authority, social workers and healthcare professionals who came into contact with the home to get their views.

At our inspection we spoke with relatives who were in the home and looked at the questionnaires from relatives about their family members respite stay. We observed the care and support staff provided to people in the communal areas of the home and during the lunch time meals. There were up to five people staying across the four days we visited and we spoke with them and observed how settled they were in the house. We read eight care files: two of the long stay people and six files of people who came for respite care on a regular basis.

We spoke with four care staff and three seniors, the day to day manager, the registered manger and the operations manager for the service. We read the personnel files and development files for six members of the staff team.

We looked at records that related to how the home was being managed. This included quality monitoring records and records related to maintenance and fire and food safety.

Inadequate

Is the service safe?

Our findings

Some of the people who were resident in the home had difficulties with verbal communication due to their disability. We observed people during the inspection and we judged that people were at ease around staff and responded favourably to staff approaching them.

A relative we spoke with said, "The staff are all good and I feel my relative is safe here."

We looked at how people were protected from abuse and avoidable harm. Staff told us that they had received training that made sure they had the correct knowledge and skills to be able to protect vulnerable people. The training records we saw confirmed this. Staff were able to explain how to identify and report different kinds of abuse.

We did, however, find evidence to show that people had been exposed to the risk of potential or actual abuse and that the registered manager and the staff team had not identified or reported this appropriately. Some instances of potential abuse had been reported to the local safeguarding team but we found that the staff team had not always carried out some of the recommendations made by social work staff. Other instances of potential abuse had not been reported appropriately.

We judged that the registered provider had not protected people against the risk of potential or actual harm or abuse This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service was managing and reducing risks to people. We found that risks were not always identified and managed in order to protect people using the service. We had evidence to show that there were some people who were at serious risk of harm but their risk assessments were not up to date or accurate. For example we saw a major risk in one person's daily notes but this was not recorded in the risk assessment or in the care plan. We discussed this with senior staff but when we revisited the risk was still evident in the home. Staff knowledge, across all grades, about this particular risk was inconsistent, with some staff having no knowledge at all about the risk.

We found that the registered provider had not protected people as they had not done all that was reasonably practical to mitigate risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the staffing levels for Cavendish House. The staff rota showed that there were usually two care staff and a supervisor on duty during the day and one staff member awake on duty at night. Staff delivered personal care, cleaned the home, did the laundry and cooked meals and snacks. They also told us that they had a lot of 'paperwork' to complete because of the frequent admissions and discharges. Staff told us that they felt they could not deliver care and support appropriately because of the tasks they had to do and the nature of the service. The mix of people and frequent admissions and discharge made this a complex service to manage. The registered manager also managed other services and told us that she did not have daily

contact with the service.

Care staff told us that people's needs could be extremely variable. We were told that, at times, people had to be monitored on a one to one basis and kept 'in line of sight' by staff. We saw on the inspection that this did not always happen. Staff also reported that sometimes people had to wait to be given personal care.

We found that the registered provider had not protected people against the risk of unsafe care by the means of ensuring adequate staffing levels. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cumbria County Council had suitable staffing policies and procedures which covered recruitment and disciplinary matters. We reviewed recruitment procedures in the service. We saw evidence that all of the current staff in the service had up to date employment checks including references and background checks.

We looked at how the service managed medicines. We observed medicines being handled and talked with staff about how they carried out medicine rounds. We looked at the medicines in stock, records and care plans. We found that staff were managing this area well and had received training and checks on their competency.

We reviewed the processes in place for the prevention and control of infections. We saw that staff used personal protective equipment appropriately. Staff told us they had training in infection control and in the safe handling of food. However, we found a number of areas of the home were unhygienic and dirty despite quality monitoring being in place. We saw that bedrooms described as being fully cleaned and decontaminated for the next person coming to stay had not been thoroughly cleaned.

Due to the age of the building some flooring and surfaces were difficult to clean and keep to hygienic levels due to being cracked and worn. This was evident in bedrooms and in bathrooms and toilets. These all posed infection control and cross contamination risks to people living and working in the home. Staff had reported to us that as well as care responsibilities they were also expected to clean and cook. They said that they prioritised meeting peoples care and support needs and sometimes cleaning was not done to the expected level.

We found that the registered provider had not protected people against the risk of infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We talked to staff about the support they received to develop in their role. We were told by all staff that formal staff supervisions were not up to date. We checked on records and found that some supervision and appraisal were out of date and lacked detail for all staff. This meant that staff had not been given the chance to discuss their training needs, personal matters or any concerns in a formal way. The day to day manager had not had supervision for several months despite the fact that she was running the home. The registered manager had not provided supervision or appraisal for the staff team.

Staff said that in the past there had been group supervisions and team debriefs which had been helpful in reflecting on practice, developing team work and improving individual practice. These had not happened recently. Staff told us that they did not feel they were getting support from senior staff or the organisation. We looked at the arrangements in place to support staff to develop the skills they needed to effectively meet people's needs.

We checked training records for the staff and saw that they had received training in some aspects of health and social care including moving and handling and safe handling of medication. All the staff had vocational qualifications in health and social care. We found that staff had received no training in carrying out risk assessments or assessments of need. Staff had attempted to put new assessments in place but these assessments still did not provide suitable guidance to reduce risk or provide guidance for care and support. While staff had formal training in managing behaviours that challenge we found that this was not reflected in care plans and instructions to staff were not in enough detail.

We found that the registered provider had not taken appropriate steps to ensure that staff received appropriate support, supervision and appraisal as is necessary to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the home was applying the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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. 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 saw that some people had restrictions placed on them. Some people did not leave the home without

staff accompanying them. Doors were locked to prevent people from entering or leaving specific areas of the home. These measures were intended to keep people safe. However these actions placed restrictions on people and as such required assessment under the Mental Capacity Act 2005 as a potential deprivation of liberty. Some of these restrictions had been in place over a period of time and the necessary assessment and referrals had not been made. Care plans did not explore the least restrictive ways of supporting people when they lacked capacity.

When we looked at care files we found evidence that capacity had not been assessed and documented. In the majority of files there was no assessment or mention of capacity or consent. Where people lacked the capacity to consent there had been no 'best interest' meetings held. When we spoke to staff they had little understanding of capacity or consent and felt that this was not something they should be carrying out for people. Staff told us that social workers did this but had not asked for support to carry out 'best interest' reviews for decision making.

We found that the registered person had not acted in a timely manner to ensure sufficient measures were in place to protect people's rights and to gain, wherever possible, their informed consent and provide care in the least restrictive way. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care staff team prepared meals, drinks and snacks for people as part of their caring duties because the home did not have catering staff. We observed a lunchtime meal and saw that people received individual support in a discreet and patient manner, with equipment available to be able people to eat as independently as possible.

There was a wide variety of food available in the home but this also included high sugar and fat foods that staff gave to people who needed support to eat a healthy diet. While some staff had received training in nutrition this was not being put into practice and staff were sometimes giving people diets that were impacting on their health. Menu planning did not always reflect a healthy and balanced diet. The kitchen was not designed for domestic use. This meant staff couldn't help people to prepare their own food.

We saw some nutritional assessments on file but one person who had gained weight during an extended stay had no nutritional assessment and the care plan did not give sufficient guidance for staff. There had been no referral to a dietician and we had evidence to show that staff gave this person high fat and high sugar foods. We also had examples of a person identified as possibly being malnourishment due to their condition. The planning and recording for these people was insufficient to monitor the care needs. It was difficult to tell if food and fluid intake were to an appropriate level because recording lacked detail and was inconsistent.

The registered provider had failed to ensure that people were protected from malnourishment because nutritional assessment and planning had not been carried out appropriately. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had evidence to show that staff called on the services of local health professionals when people were unwell. They also spoke with families or other carers if there were concerns about health prevention or treatment when people came for respite. We received positive feedback from health professionals about staff in the home contacting them promptly and appropriately and following the advice given. However we also found evidence to show that the follow-up for requests for specialist involvement was poor. We saw a diary recording about staff needing to make a request for a consultant appointment that had taken six weeks to be actioned.

We also saw that concerns around nutrition, falls and other problems that might have been related to health conditions did not alert staff to contact health care professionals. Some files had no health action plan on file. One person's health action plan was last updated in 2010.

We judged that the provider had failed to ensure that people always received suitable health care support. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cavendish House was not designed to meet the needs of people living with a learning disability. There was no safe space for people to make their own drinks or snacks, nor to learn kitchen or laundry skills. The home did not make use of assistive technology to help lessen the restrictions on people. Whilst there was a sensory room the home did not make use of IT or computers for leisure or for promoting communication with people.

The home was built in the 1960s and had not had a major upgrade for some time. The provider had reduced the size of the home and the upper floor was used as offices for a home care service. The two parts of the building had not been adequately secured. A stair well was used by a number of staff and other visitors who could see into the home. People in the home had, on occasion, left the home and gone up to the office floor. Some of the external doors were not as secure as they could be and this may have posed a security risk.

We walked around all areas of the home. Staff had supported long stay people to personalise their rooms to some effect. We looked at bedrooms intended for respite (or emergency) stays. These rooms were not ready for occupancy as they were not as clean or tidy as they might be. Dusting and more thorough cleaning had not been done. Radiators were loose and rusty. One person had received an injury because of a loose radiator cover.

The home had no ensuite toilet or bathroom facilities. Some of the bathroom equipment and fittings needed to be replaced and the rooms upgraded as there were infection control hazards. The dining room table was very worn and wrapped. We asked that this be remedied as it posed a serious infection control risk. The provider replaced this the following day. Flooring was worn and torn in some areas which made floors difficult to clean. The home did have suitable moving and handling equipment and we did see that some minor upgrades had taken place there was new furniture in the three shared areas. Staff had made efforts to make the shared areas more homely. However, overall the home was in need of modernisation and refurbishment.

Externally we saw some evidence of problems with down pipes and guttering. Brickwork was stained which could have indicated problems with water ingress. Window frames had rotted. The garden at the rear of the property was not secure. Paving stones were uneven and this posed a trip hazard. The garden was not conducive to people enjoying being outside. The home was not designed to give people on respite the opportunity to engage in sport or games or to have a 'holiday' experience.

The fire safety system covered the whole building. There was a lack of clarity about who was responsible for fire safety but staff in the home were responsible for both the home and the office space out of office hours. Cumbria Fire and Rescue service had made some recommendations about fire safety but these had not been completed when we visited.

The registered provider had not ensured that the environment was suitable for people who used the service. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not ensured that the premises was fit for purpose and took into account

national best practice.

Requires Improvement

Is the service caring?

Our findings

We observed staff supporting people in a kind and caring way. The staff we observed treated people respectfully and had received suitable training on concepts like equality and diversity. When we visited we judged that staff helped people to maintain as much privacy and dignity as possible.

We looked at how the service supported people to express their views and be actively involved in making decisions about their care and support. People were able to access advocacy services if they required support. We did not find evidence to show that this had been done in a proactive way. It was difficult to discover whether people were happy with their respite stays. Neither the provider not the inspectors knew if the diverse group of people who used the service had ideas about what they wanted from their stay. Families had been contacted and they were happy with the care provided but there was little evidence of people being given different experiences during their stay.

The Statement of Purpose for the service included "We aim to provide activities and opportunities, which enable personal development and growth". Staff said that some people came to Cavendish House for, "a holiday" and that this was how they explained the stay to some individuals. There was nothing in the care planning or the activities on offer to show that these 'respite' stays helped people's wellbeing or gave them a holiday from their routine.

We found scant evidence of people being encouraged or supported to learn new skills and become more independent. Staff gave people care and support but person centred planning was not used to help people develop skills or to have different experiences. Independence building was not to the fore in care planning and we found very little evidence to show that this was discussed with family carers, social workers or any other professionals who were involved with the care and support.

Some people had been in the home for some time awaiting another, possibly more permanent move. There was no evidence of skills assessment or independence building with these people There had been no goal setting to develop skills to enable growth to cope with a new placement.

Staff did explain interactions to people in a kind and patient way. There was suitable 'easy read' information available from the provider. People who were in the home for extended periods of time had not been supported to develop their goals or their person centred plan. People did not have ready access to their care plans in a format that they could follow.

It is recommended that the registered provider ensures that measures are put into place which will mean that due regard is paid to individual well-being and the promotion, where possible, of independence and skills building in line with current national good practice.

Inadequate

Is the service responsive?

Our findings

We measured how responsive the service was by observation and by reviewing care and other documents. We found that people were given basic personal care in an appropriate manner.

We looked at a number of care plans for people who had been in the home for extended periods and for people who came for short stays. We found that care plans did not always reflect the assessed needs of people who used the service. Care plans lacked detail, were not always person centred, had not been reviewed when needs changed and lacked goals for individuals. Assessments and care plans were not being completed or reviewed by staff with the skills, competence and experience to do so. Care plans and assessments were of a poor quality and routinely reviewed stating "no change." We found that there was a lack of direction for staff within the unit to ensure that they were following care plans.

We looked at moving and handling plans which did not always reflect the assessed need. The plans lacked precise detail for some people who needed support and the use of specialised equipment. One person's plan gave contradictory advice about use of equipment while supporting a person to shower.

We also looked at care files for people who may have found it difficult to manage their behaviours and emotions. We found that the care plans for these people lacked suitable guidance for staff. In one file we saw that an issue of this nature identified through a safeguarding strategy had not been detailed in the care plan.

We found that the registered provider had not ensured that people received care and treatment that was appropriate in meeting their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were spending their time in the home and how the home was meeting people's social, cultural and recreational needs. We could not find evidence of structured outings, entertainments or activities for people who were coming for short stays. Activities that people liked to do were listed, such as walking, swimming, shopping, horse riding. We checked the weekly activity records and found that people had not been offered these activities and had been left for long periods with no stimulation. Sometimes people did not leave the building for a whole weekend. When we visited we met people who had been in the lounge watching TV for long periods of time because there was not enough staff to take people out or to engage in activities. There was no proactive work with people to develop skills like cooking, household tasks or managing personal care tasks. There was no assessment or development work by the home to help longer stay people with the skills they might need if they were to go to more independent living situations.

The registered provider had not ensured that people had been offered meaningful activities that would prevent social isolation. This was a breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cumbria County Council had a suitable complaints and concerns policy. There was a procedural document

for staff to follow. Relatives were given a guide about how to raise a complaint and there was an 'easy read' version available for people who needed pictorial guidance. We had not received any complaints before we visited and there had been no formal complaints received by the registered manager.

We looked at arrangements in place for people moving between services. We saw that the difficulties the team had with ensuring good communication between shifts also applied to communicating with the day centre when people attended during their stays. We also questioned why emergency placement service users had been in the service for extended periods of time. One person had been in the home for more than a year and another for four months. The initial reason for social workers arranging admissions was to assess needs and ability so that appropriate long term placements could be found. This hadn't been done and the registered manager had not worked proactively with social workers to help facilitate people moving on. This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

This service had a registered manager and we asked her to be present on the second day of our inspection. This person told us that she had only agreed to take on the role to fulfil the requirements of the Care Quality Commission. She already ran other registered services for the provider and had informed the operations manager that she was unable to run Cavendish House given her other tasks and responsibilities. When we visited she was in the process of de-registering from the role of registered manager for Cavendish House. A new manager had been recruited and was awaiting a start date.

We found evidence to show that the registered manager was not in day to day charge but that this role had been delegated to a 'manager' by the provider. The registered manager had not supervised staff, had no access to the budget and did not have an understanding of the care needs of people who used the service.

We met with the operations manager for the service who confirmed that these arrangements were known to her and that she visited the service on a regular basis. She had control of the budget. We could not find evidence of supervision of the person who was actually managing the service. Senior members of the team told us that all the staff team would benefit from training on how to draw up risk assessments.

We judged that these arrangements meant that Cumbria County Council had not given suitable attention to good governance. There was a quality monitoring system in place but this had failed to identify the problems with the scheme of delegation and had not dealt with issues around the environment, care delivery or staff competence. These problems had not been dealt with by the operations manager, the registered manager nor by the provider's quality monitoring team.

Staff told us that they felt that they were not supported by the organisation and that the difficulties of staffing and the environment had not been recognised by the provider. They told us that the supervisor tried "really hard to keep things running" but all of the staff (including the supervisor) said they needed a registered manager to guide them. Staff were aware of the values of the County Council but said that they often needed guidance about how to apply principles in practice.

The provider had failed to identify many of the matters of concerns we found during this inspection. We were unable to access any kind of business or operational plan for the service that would support improvements in the service and promote well-being and independence in service users. After our inspection the nominated individual for the provider agreed that there had been failure in matters of good governance which needed to be investigated.

This meant that the registered provider had failed to identify these problems in governance and quality monitoring. This was a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also had evidence to show that the provider had failed to notify the Care Quality Commission of safeguarding matters and other matters of concern. This was a breach of Regulation 18 of the (Registration)

Regulations 2009 by Cumbria County Council or the Registered Manager. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people who used services appropriately because suitable risk assessments and risk management plans were not in place to support care delivery, the environment and staffing matters. Regulation 12 (1) (2)(a)(b)(c)(d)(e)(f)(h)(I)

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 The provider had failed to ensure that people were suitably protected from potential or actual harm and abuse. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure that suitable assessment and planning was in place to give people appropriate nutrition and hydration. Regulation 14 (1) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were safe and suitable for vulnerable adults because maintenance and improvement were

not being carried out appropriately. Regulation 15(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to provide suitable management and quality monitoring arrangements and this had led to the service failing to give good standards of care and service delivery. Regulation 17(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to give people suitable levels of care and support because sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of vulnerable adults. Regualtion 18(1)(2)