Chase Community Homes

The Bungalow

Inspection report

1 Short Street
Brownhills
Walsall
West Midlands
WS8 6AD

Tel: 01543372333

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07 April 2016
08 April 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

The Bungalow is a residential home that provides accommodation and personal care for up to seven people with autism and learning disabilities. At the time of our inspection there were five people living at the service. The provider is required by law to have a registered manager, however, there was no registered manager in post during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found widespread and significant shortfalls in the service.

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

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

People were asked for their consent to day to day tasks and activities. Where people did not have the ability to give consent we found that decisions were not always made in line with the Mental Capacity Act 2005. People's day to day health needs were met and they were supported to see healthcare professionals. Where more specialist support was needed managers were not always proactive in seeking this support.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

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

Is the service effective?

Inadequate

The service was not effective

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

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

Is the service caring?

Requires Improvement

The service was not always caring

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

Is the service responsive?

Inadequate

The service was not responsive

Staff did not support people in a way that met their individual needs and promoted their well-being. People were not always enabled to be fully involved in the planning of their care. People's care and support plans did not always accurately reflect their needs and preferences.

People were able to access a structured activities programme although this was not always tailored to people's individual needs and preferences.

Is the service well-led?

Inadequate

The service was not well-led

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

The Bungalow

Detailed findings

Background to this inspection

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

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

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

Shortly after we had visited the service the provider sent us their 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 used this information as part of our inspection.

Inadequate

Is the service safe?

Our findings

People were not able to share their views about how safe they felt living at the service so we completed observations of the care provided. We observed that risks to people were not always identified and managed appropriately in order to protect them from harm. For example, we found that one person had several allergies identified in their care plan. Staff members, the manager and deputy manager were not able to describe what sort of allergic reaction the person would experience and had not identified what they needed to do to keep the person safe. Following our intervention the manager investigated this person's allergies with medical professionals and relatives. The manager identified that one allergy could result in anaphylactic shock. Anaphylactic shock can result in the loss of life if not treated appropriately. Staff had not been aware of this risk and there was no plan in place to manage the potential risks to this person. We found further examples where people's health concerns and behaviours that could cause them harm needed to be monitored and risks managed by staff. Staff members we spoke with were not aware of all of the potential risks to people and therefore action had not been taken to keep people safe from the risk of harm. In addition, people's care plans and risk assessments did not provide staff with the adequate guidelines about how to mitigate against these risks. The provider had not ensured that risk assessments were effective and staff had the required knowledge to protect people from harm.

We found one person was displaying behaviours that could result in serious harm to other people living at the service and these had not been managed effectively by the staff team. The manager was not able to confirm how long these incidents had been occurring. However, we found records identifying incidents relating to the eight month period leading up to the inspection. Multiple incidents resulted in attempted or actual harm to other people living at the service. The provider and manager were not aware of all incidents that had arisen until the inspection. Other staff had failed to take appropriate action to escalate and protect people from future occurences, despite completing and reviewing these reports. This person's care plan and risk assessments did not provide sufficient guidelines for staff about how to manage the risks to other people at the service. Some staff were not aware of all the incidents that had occurred and several staff members told us they thought this was no longer occuring, despite us identifying incident records in the weeks prior to the inspection. An incident relating to this behaviour also occurred during our inspection causing harm to one person. The provider had failed to ensure the risks to people at the service had been identified and appropriately managed to keep them safe.

We found further examples where risks to people had not been identified and effectively managed. For example, we found that one person demonstrated a behaviour that resulted in self harm. The provider had completed repairs to the environment within the service that increased the risk of injury to the person when they displayed these self harming behaviours. The potential for an increased risk of injury as a result of these repairs had not been considered by the manager or by the staff we spoke with. The provider had failed to ensure the risks to this individual were appropriately assessed and staff had the knowledge required to protect the person from the risk of injury.

We saw that some risk assessments were generic and did not identify how to manage people's individual risks. For example, we saw risk assessments were the same for some people with only their names changed.

Staff gave inconsistent information and had different views on how they should support people and protect them from the risk of harm. We spoke to staff members, the deputy manager and the manager about how they monitored and analysed behaviours in order to identify triggers. The identification of triggers can enable providers to develop systems to assist with the reduction of behaviours that challenge, management of any associated risks and protect people from harm. We were told by the manager, deputy manager and staff that there were no systems in place to effectively identify the cause of behaviours and as a result appropriate prevention strategies were not in place. We found that the manager was not proactively involving social care professionals and behavioural support teams to assist with managing risks associated with certain behaviours. They had not recognised the need to do this. We saw that staff did not always appear to have the skills and knowledge required to safely manage behaviours that challenged. One staff member was not able to tell us how to safely manage the behaviour of one person without increasing the risk of harm to themselves or others. The provider had not ensured that staff members were safely managing risks to people and behaviours that challenged in order to keep people safe.

Risks to people's health and safety had not been adequately assessed and appropriate action had not been taken to protect people from the risk of harm. This was a breach of Regulation 12 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

People were not always protected by the safe management of their medicines. We found that staff and managers had not identified relevant issues with medicines and made the required referrals to either the person's doctor or pharmacy. We found that two people were taking a medicine to aid with their sleep. The tablet was designed to slowly release medicine to these people over a period of time after they had taken it. Staff were crushing the medicine and dissolving it in water which may impact on the effectiveness of the medicine. These people were both experiencing disturbances in their sleep. Staff had not identified there were conflicting instructions on the medicines and had not queried it with the doctor or the pharmacy. Staff had also not identified the disturbances with the sleep patterns of these people and as a result had not sought advice about the effectiveness of their medicines with the doctor.

The provider had failed to ensure that controlled drugs were stored securely and that these medicines were accounted for. Controlled drugs are medicines that have specific legal guidelines around their storage and use in order to prevent them from being misused or causing harm. We saw the controlled drugs register did not accurately record how much medicine was in stock. There were nearly five times the quantity of controlled drugs in stock than were accounted for on the register. We found when controlled medicines were administered the amount administered was being recorded inaccurately. The provider was not able to account for the controlled medicines being stored in the service. The provider had also failed to ensure that there were safe systems in place to return unused or discontinued medicines to a pharmacy as required by law. We identified there was a large quantity of medicines that needed to be returned to the pharmacy, some of these medicines were several months old. We asked the deputy manager why these medicines had not been returned and they were not able to provide an explanation. They advised that there had not been a system in place for returning medicines until March 2016. We saw that there was a log of medicines that required returning from March 2016. However, the deputy manager confirmed that there was no record of the older medicines awaiting return to the pharmacy. None of the medicines had been returned at the time of the inspection. The provider had failed to ensure that all medicines stored in the service were safely accounted for.

Where people had been prescribed new medicines by their doctor, they were not always obtained for people's use promptly. We found one person had been prescribed a topical cream during the week prior to the inspection, however, it was not on their medicines administration chart (MAR). The deputy manager advised that the medicine had not been delivered by the pharmacy and they were not certain if this had

been followed up by anyone at the service. In response to our concerns the deputy manager contacted the pharmacy and the medicine subsequently arrived at the service on the last day of our inspection, a week after it had been prescribed. The provider also did not ensure that all medicines were stored in line with manufacturer's guidelines. We found the temperature of the medicines storage area was not monitored to ensure that it remained in a recommended range to keep medicines safe. We were told by staff and the deputy manager that the medicines fridge had broken several months prior, however, no action had been taken by the provider to obtain a replacement. We were told by staff that if people required medicines that needed to be refrigerated, these would be stored in the kitchen fridge. The manager had not considered whether this facility meant that medicines were adequately secured and kept safe.

Protocols were not always in place to outline when people should receive important medicines on an 'as required' basis. We found that one person was prescribed an antipsychotic medicine on a regular basis, however, they were also prescribed this medicines on an 'as required' basis. Staff had not administered the medicine to the person on an 'as required' basis despite them displaying symptoms such as self harming behaviour. We asked the deputy manager when this person should receive this medicine. They were not able to outline this and agreed that a protocol was required. We saw that several people required pain relief medicine on an 'as required' basis and protocols were in place for these medicines. These protocols, however, did not outline how to identify pain in people that were not able to tell staff when they needed them. Some staff members were able to describe how to recognise when people needed these medicines but others were not. The provider had not ensured there were systems in place to make certain people received 'as required' medicine when it was needed. We looked at the training records supplied by the manager and found the manager responsible for overseeing medicines management did not have current, 'in date' training in medicines. The provider had not ensured that managers responsible for managing medicines had the required skills to ensure this was managed safely.

Medicines had not been managed safely. This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

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

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

People had not been protected from the risk of abuse and improper treatment and systems had not been established to prevent the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People were not always protected from potential harm due to recruitment practices that failed to ensure staff were suitable to work with vulnerable people. We found one member of staff was working without any references having been obtained. The check completed on their potential criminal history had identified information which needed to be investigated further to ensure their suitability for work. We found this information had not been investigated and the risks to people living at the service had not been assessed. The manager, deputy manager and provider were unaware that this person was working without references until we identified this during our inspection.

We found other examples where staff member's suitability to work with vulnerable people had not been sufficiently explored. For example, one staff member was employed without their employment history having been identified and the identity of their references had not been checked. We found that staff members were starting work without a check on their criminal history having been obtained. The manager and staff told us that staff members were not able to complete any personal care while this check was pending, however, they did work with people living at the service. We asked the manager if they completed any checks to see if staff were 'barred' from working with vulnerable people before they started work and they confirmed that they did not. The provider had not ensured that there were safe recruitment practices in place to ensure that people were kept safe in their home.

Effective recruitment procedures had not been established. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons

People living at the service were not able to share their views about whether there were sufficient numbers of staff to support them. Relatives and staff members told us they felt there were enough staff members to meet people's needs and this was reflected by what we saw during the inspection. We found that the deployment of staff could however be improved in order to ensure staff were able to be more responsive to people's needs. For example, staff members who supported people who chose not to go out for the day were required to complete domestic tasks. This meant they were not always able to focus on the people needing support. The provider told us during the inspection they were considering employing domestic staff to make improvements in this area.

Inadequate

Is the service effective?

Our findings

People were not supported by staff who had the skills and knowledge to support them effectively and safely. Relatives we spoke with expressed mixed views about the skills of the staff team. While some relatives told us they thought staff were well trained, one told us, "I don't think some of the staff are well trained, no. Some of the [staff] do not appear to have the knowledge and skills about how to care for people". The manager provided us with information about staff training and we saw there were some key areas in which staff had not been trained. For example, we saw staff had not been trained in areas such as physical intervention, risk assessment, nutrition, autism awareness and Makaton. Staff confirmed that everyone living at the service had autism and some used the communication system Makaton. In addition, people using the service sometimes displayed behaviour which may cause harm to themselves or others. The manager said they did not check the competency of staff members to ensure the training they had received was implemented effectively and that staff had the skills needed in their role.

We found the lack of appropriate staff training had impacted on the staff team's ability to support people effectively and keep them safe. For example, staff were not aware of the importance of monitoring people's behaviours in order to develop strategies that responded appropriately to people and reduced the risk to themselves and others. One member of staff told us if people tried to injure other people they would protect them by putting themself at risk and standing in the way. This was not a technique outlined in the person's risk assessment but a method that the staff member had developed. They told us they had not received clear guidelines or training on how to manage these situations. Staff had not been given the knowledge or training to understand why people may display challenging behaviours and so were not equipped to protect themselves, the person and others when managing behaviour that challenged. For example, we saw staff did not always provide appropriate support responsively which caused an increase in some people's anxiety. The staff did not have the knowledge to recognise that the way they were supporting people impacted on their behaviour. The manager told us that additional training was underway, for example in areas such as autism. However, the provider had not ensured staff members were receiving the training they required to be effective in their roles. They had also not ensured staff members had the required competency to support people effectively.

We found there was a high percentage of new staff members within the care staff team. We saw an induction was completed with new staff members. We found there was time allowed for new staff members to familiarise themselves with care plans and risk assessments. However, as care planning information was not accurate and provided limited guidance on how people should be supported, staff were not always equipped with the knowledge they needed to provide effective care and support. The provider had not ensured systems were in place to ensure that new staff members fully understood people's support needs. People were receiving care that did not always meet their individual needs and keep them safe because staff did not have sufficient training or knowledge.

People provided consent to staff for their day to day care and support needs during the inspection. Staff were able to explain how they would recognise if someone did not want support and told us they would obtain consent. Relatives told us they felt consent was sought from people before care was provided. One

relative told us, "[My relative] cannot verbally communicate but is able to let people know if [they don't] want something to happen".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that staff and managers were making decisions on behalf of people when they didn't have the capacity to provide consent or make decisions about their own care. However, these decisions were not always being made in line with the MCA. We found that assessments of people's capacity were present in people's care plans, however this covered a generic list of different aspects of people's care. These assessments were the same in each care plan we looked at and were not individual to the people living at the service. The assessments did not reflect people's own individual abilities in making decisions and providing consent. We asked the manager, deputy manager and staff about how they made decisions on behalf of people who lacked capacity and they were unable to describe the key principles of the MCA. The provider had not ensured that capacity was being assessed in line with the MCA and had not recognised the need to follow the principles of the MCA.

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 saw that where staff felt people were lacking capacity and they had been deprived of their liberty in order to protect their health and well-being, applications had been submitted to the local authority. However, where DoLS applications had been authorised by the local authority, managers and staff were not always aware of the details of the authorisation. We found they did not follow agreed actions documented in the authorisation to keep people safe. For example, one assessment highlighted that continuous supervision was required for one person at night due to specific risks. Staff members that we spoke with, the manager and the deputy manager were not aware of these risks and were therefore not abiding by the requirements of the DoLS authorisation.

We looked at the support people were given to access healthcare professionals when required. We saw that people were enabled to see professionals such as the doctor, dentist and chiropodist. We found that while people were supported to access routine appointments, the manager and staff were not always proactive in following up more specialist appointments. For example, one person was identified as requiring a hospital appointment for dental treatment. The manager told us that they felt this concern was impacting on the person's behaviour, however, they had not ensured this appointment was followed up proactively. People were not always supported to access specialist health and social care support promptly.

People were not able to share their views around the food and drink available to them. However, we saw that people appeared to enjoy the food they ate. We looked at the food diaries for some people living at the service. We found that people were not always supported to make healthy choices. For example, we saw that people ate a large amount of food items such as chips and pastries. Care plans and capacity assessments did not demonstrate how people were supported to make nutritious choices in order to maintain their health. We saw that a menu plan was available for people which was developed by the manager. Staff told us that they offered choices to people from the menu using picture cards before each meal. We saw a staff member provided choices to one person in this way just prior to cooking their chosen meal. One relative told us that staff understood their relatives food preferences and how to ensure they ate sufficient quantities. Staff were able to describe to us who needed additional support at meal times and we saw this support was provided.

Requires Improvement

Is the service caring?

Our findings

People were supported by a staff team that were caring and told us they were committed to providing the right support to people. One staff member told us, "It's their home. We're just working here, they live here." However, we found that staff did not have the skills to recognise when support provided was not always caring. We saw examples where people's needs were not fully considered and the approach by staff was not caring. For example, we saw staff recognise that one person had become anxious. Staff used picture boards to identify this person wanted to get on the bus to go on their planned outing. Following this, we saw the person become increasingly anxious over a period of nearly half an hour. Staff did not make any attempts to alleviate this person's distress during this time despite having identified the cause. We also saw one person had finished watching a DVD in the lounge. Despite staff being aware the DVD had ended they made no attempt to support the person and as a result the person displayed signs of boredom and began pacing around the lounge area. Staff were not ensuring that the needs of people were considered and met appropriately in a consistently caring way.

Relatives gave us mixed views about the approach of staff and if they were caring. One relative told us that staff treated people well and communicated with them. Another told us, "When I have visited I have seen staff shout at other residents when they are not doing something they want them to do and it worries me they may be like this with [my relative] when I am not there". They told us, "I never see the staff talk much to [my relative] unless they are asking [them] to do something" The manager confirmed to us that they had no methods in place to assess the competency of care staff in their role and that their care practice, including how they supported people, was not observed. The provider had not ensured that care practices were considerate of people's needs.

People were supported to make day to day choices. For example, we saw that people were able to decide if they wanted to take part in any activities that were taking place outside of the service. They were offered choices around their food and how they spent their time while at home. We saw that people were supported to personalise their bedrooms. One staff member told us, "It's their sanctuary. It's where they go to calm down." We saw that people were able to move around the service independently and without restriction. People were encouraged to complete their own shopping with the support of staff members in order to support their independence.

We saw that family members were involved in people's care, however, we received mixed views around the level of involvement. We spoke to the manager about the use of advocates as there were none being used. They told us that they had not considered the use of advocacy for anyone living at the service but would review the appropriate use of advocates across the service.

People's privacy and dignity was protected by staff when supporting them with personal care. Staff were able to describe how they would protect privacy and dignity and relatives told us that they felt this was respected. One relative told us, "They won't talk in front of other people, things like that". We saw that privacy was respected when completing personal care, however, we saw that people were not always treated or addressed in a dignified way. We identified from one person's care records that staff had refused

to offer them pudding as they hadn't eaten their main meal. We discussed this with staff and the deputy manager and they acknowledged that this was not a respectful and dignified way to treat people. The provider had not ensured that people were consistently being treated in a dignified and respectful way.

Inadequate

Is the service responsive?

Our findings

People's care plans did not accurately and consistently reflect their care and support needs. We found that while the manager and deputy manager updated care plans and reviewed risk assessments, this process was failing to accurately identify and reflect people's needs. As a result the staff team were not always responding appropriately to people and ensuring they met their individual care and support needs in an appropriate manner. We found from speaking to staff and managers that one person had several health conditions that were not included in their care plan. Staff and managers were not able to outline what specific support needs this person might have due to these health concerns and so this had not been monitored or responded to. Where people's needs were correctly identified in care plans we found that these needs had not been effectively communicated to staff members. For example, we found two care plans outlined some specific requirements regarding people's care. Staff were unaware of one instruction regarding monitoring a health concern. We confirmed with a social care professional that this instruction was important and still relevant to the individual. The second instruction had recently been added to the care plan by the deputy manager, however, staff were not aware of this instruction due to ineffective communication systems. The deputy manager had outlined in the care plan some instructions for staff to follow when supporting the person to the toilet. Staff had not been advised of the updated care plan and therefore were not aware of the instruction when we spoke with them. There were some entries in care plans that staff and managers were not able to explain. For example, one care plan stated that one person should eat as much meat as possible without an explanation as to why. The deputy manager was not able to explain why this requirement was in the care plan and what the importance was to the person's health or well-being. The provider had not ensured that people's support needs were accurately assessed, documented and communicated to the staff team. As a result staff, did not have a consistent understanding of the most appropriate way to support and respond to people so as to ensure their health and well-being.

People were not included in the planning of their care. We saw that review meetings were being held, however, these were not inclusive of people using the service. We saw that aims had been set in people's care plans, however, these were not the aims of the people themselves. For example, we saw aims that read 'My aim is to respond positively to staff asking me to limit my volume when vocal' and 'My aim is to continue to develop my listening and respond appropriately'. We asked the manager and deputy manager who had set these aims and they confirmed that they came from review meetings and were not necessarily the aims of the person. We asked the manager whether they had considered any alternative ways of involving people living at the service in their care and support outside of formal review meetings. They confirmed they had not. Relatives we spoke with told us they were able to attend review meetings but they had not seen care plans. The provider had failed to ensure that people and their representatives were fully involved in planning their own care.

People were given the opportunity to participate in an activities programme that ran each week. This included sailing, days out and visits to the local day centre. We found that the activities programme had not been varied for over a year and was rotated each week. Staff and managers had not worked to identify unique activities that each individual could enjoy based on their own interests. One relative told us that staff had mentioned that their relative liked a particular hobby. They told us that they had not seen, through their

visits to the service, their relative participated in this hobby. A relative told us, "I don't think there are enough activities in the home or times for [my relative] to go out". We were told by the relative that they felt people sometimes demonstrated behaviours because they were bored. We observed there was minimal interaction between people living at the service and staff during certain periods. We spoke to the manager about the activities programme who acknowledged that improvements could be made.

People were not able to share their views with us about how they would raise a complaint. We saw that surveys had recently been completed with people living at the service using a pictorial format. Relatives told us they felt able to raise a complaint if this was needed. One relative told us that they'd made a complaint and this had been resolved. The manager told us that they had not received any complaints for the service. The manager explained to us that they only recorded formal written complaints and did not log any verbal or informal complaints that were made. They told us that they would start to log all comments received moving forward to enable them to identify areas of improvement needed in the service.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of the inspection. The previous registered manager had not been active in their role since 2014. The provider had failed to ensure that an appropriate registered person was in post and running the service.

This was a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009 Registered manager condition

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

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

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

We found that care plans were not always reflective of people's care and support needs. The provider had not developed systems to ensure the care and support people received met their needs. They had no system in place to ensure that reviews of care plans were effective and accurately identified people's current support needs. They had no system in place to ensure that staff skills were sufficient to provide effective support to people. The provider had failed to ensure that staff knew and understood people's care and support needs. For example, we found that one person had significant health and behaviour management requirements that staff did not fully understand. This lack of understanding put the person and others at risk of harm. The provider had failed to ensure that the support provided met people's needs and kept them safe from harm.

We looked at the quality assurance processes that were in place and found that while audits were completed, these were not effective at identifying the significant issues we found during our inspection. Due to the inadequate auditing of care plans and records relating to accidents and incidents, we found that concerns about people's health or safety were not identified. For example, people's weight was recorded and we identified people had lost weight but no action had been taken. We confirmed with staff and managers that there was no system in place to escalate these concerns and take any required action. Audits

of medicines had failed to identify the concerns that we found. For example, relating to stock counts. Where concerns had been identified by managers, for example the lack of a suitable refrigerated storage, the provider had failed to ensure that action was taken to correct the issue. We found that the deputy manager had audited some accident and incident records, however, they had failed to escalate concerns or take any remedial action to manage the risks to people. The provider had failed to ensure that effective quality assurance systems were in place to manage risk and identify areas of improvement required within the service.

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

Systems had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

People had been asked to share their views about the service through surveys. We found the provider had also completed surveys in 2016 with relatives of people and staff members. We asked the manager how these surveys were used to develop the service. They told us they had reviewed the surveys and were aware of comments made by relatives and staff but no actions had been taken as a result. We asked the manager how they involved people in developing the service or making specific decisions. They confirmed that they did not have any methods of doing this but began to consider ways that this could be done during the inspection.

We saw that staff members attended meetings with managers where information was shared about the service. Staff told us they felt managers were supportive of them and were available if needed. One staff member told us, "They have been really good. I can't fault them. They have an open door policy". Relatives gave us positive views about the managers of the service. One relative told us, "I have known [the manager] for years. [They are] very supportive and easy to reach. [The manager] follows up on everything and keeps us informed." Another relative told us they didn't have much involvement with the manager but said the provider was "very good". Relatives and staff were mostly happy with the support and contact they received from managers.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider had failed to ensure that a registered manager was in post for a period of more than 12 months.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that notifications of significant events were submitted to CQC as required by law.

The enforcement action we took:

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

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

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected by harm due to a failure to identify, report and management safeguarding incidents.

The enforcement action we took:

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

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

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected from harm due to unsafe recruitment practices.

The enforcement action we took:

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