Yarrow Housing Limited

Angela House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Angela House is a care home registered to provide care and accommodation for up to six adults with a learning disability or an autistic spectrum disorder. At the time of this inspection there were three adults living at the service. The accommodation comprises a communal lounge, kitchen diner and communal bathrooms and toilets. Bedrooms do not have en-suite facilities.

People's experience of using this service:
The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the reasons outlined below:

People were not always supported to have maximum choice and control of their lives.

Staff were not always supporting people in a kind or caring manner. We witnessed abuse taking place. These concerns are currently being investigated by the local authority safeguarding team.

Risks to people's health and wellbeing were not always being assessed, mitigated or reviewed appropriately. This impacted on people's safety and dignity.

Staff were not always supporting people in the least restrictive and safest way possible.

People were at risk of harm because staff were not always following guidelines and recommendations provided by healthcare professionals.

Incidents were not being referred to safeguarding authorities as required to ensure a thorough investigation was completed and people were protected from harm.

The environment was poorly adapted and failed to meet people's needs appropriately.

Opportunities to observe, review and adjust care practice were being missed.

The provider's systems for assessing and reviewing the quality of the service were not always effective. Improvements to the service and how it was managed were overdue.

The previous inspection rating was displayed in line with CQC requirements.

Rating at last inspection and update:
The last rating for this service was requires improvement (report published 8 August 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made to the specific issues we identified in relation to the safe storage of medicines, sharp knives and COSHH (Control of Substances Hazardous to health). However, we found repeated breaches of the regulations in relation to risk management and medicines management.

Why we inspected:
This inspection was part of a scheduled plan based on our last rating of the service and aimed to follow up on some concerns we had found at our previous inspection.

Enforcement:
We have identified repeated breaches of regulations in relation to safe care and treatment. We found further breaches related to person-centred care, dignity and respect, safeguarding, premises and equipment, good governance and failure to notify. Please see the action we have told the provider to take at the end of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

We made a recommendation in relation to home improvement and relocation plans.

Follow up:

We will contact the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our Well-Led findings below.

Angela House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Angela House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service manager was not yet registered with the Care Quality Commission. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons are legally responsible for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the provider a days' notice of the inspection site visit because it is a small service. We needed to be sure that someone would be in to support us with the inspection process.

What we did before the inspection
Before the inspection took place, we reviewed information we held about the service. This included the provider's improvement plans and notifications which providers or others send us about certain changes, events or incidents that occur and which affect the service or the people who use it.

We used all of the above information to plan our inspection.

We did not ask the provider to complete the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The provider was given the opportunity to discuss their plans for the service during this inspection.

During the inspection
People using the service could not let us know what they thought about the home because they could not communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the following records
Notifications we received from or about the service
Three people's care records and related information including daily notes and medicines records
Records of accidents, incidents and complaints
Meeting minutes
Four staff recruitment records and related supervision and appraisal documents
Training data
Policies and procedures
Audits and quality assurance reports
Health and safety records

We spoke with
A support worker, a deputy manager, an HR officer, the service manager and a director of care and support

Following the inspection, we spoke with
Two relatives
Two healthcare practitioners and an advocacy worker.
We contacted but did not hear back from two health and social care professionals based within the Hammersmith and Fulham Learning Disability Team.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

People were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we found a breach of regulation in relation to risk management. Although these particular issues had been addressed we found further issues that were impacting on people's safety during this inspection.

- Poor risk management procedures were impacting on people's safety, well-being and dignity.
- Risks to people's health and wellbeing were not always being assessed, mitigated or reviewed appropriately. For example, one person using the service had fallen four times in the past six months. A written entry in the related care documentation recorded - 'no changes needed - service user independent'. This information was incorrect. The person in question was registered blind, required assistance when mobilising in the home and used a wheelchair when accessing the community.
- Staff were not always using recommended techniques when providing people with moving, sitting and standing support. For example; we observed staff hoisting one person from their wheelchair to an armchair without explaining what they were doing, offering reassurance or attempting to converse with them in any way. We saw another person being assisted out of their chair using an underarm method and being held by the wrists whilst walking. We observed a member of staff holding a person's hands down and then leaning on this person's hands to keep them down. This was done with a level of force that was excessive and inconsiderate of their medical condition, potential pain levels, general comfort and well-being.
- The manager told us that one person required turning throughout the night to avoid pressure wounds. We saw no documentation to evidence that this task was being undertaken.

Due to poor risk management people were put at risk of harm. Therefore the issues highlighted above constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Using medicines safely

At our last inspection we found a breach of regulation in relation to the safe management of medicines. Although improvements had been made we found further issues relating to the safe management of medicines during this inspection.

- Medicines were not always being administered as prescribed.

● We raised a query with the management team about the use of a person's medicine prescribed for two weeks only. Medicines records showed that staff had continued to use this medicine beyond the stated period of 14 days. Managers provided conflicting information as to what had been agreed by the GP. We asked the management team to follow up on this concern.
● We noted that medicines cupboards contained open boxes of paracetamol. These medicines had not been prescribed by a GP and protocols and guidance around their use were not in place.

People were put at risk of harm as medicines were not always managed safely. The issues highlighted above constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● Medicines administration records (MAR) were in use and staff were completing these appropriately with no gaps or omissions.
● Medicines were stored appropriately. Staff were aware that medicines requiring refrigeration needed to be stored accordingly.
● Medicine checks were undertaken daily. Records we looked at demonstrated that these checks were taking place.

Learning lessons when things go wrong
● We reviewed accident and incident records alongside body maps and daily notes to determine whether lessons were learnt when things went wrong.
● We could find little evidence that the provider was taking steps to learn from mistakes or making necessary improvements in order to minimise repeat events and protect people from harm. For example, 15 separate incidents of injuries ranging from scratches and grazes, to unexplained blisters and bruising had been recorded for one person using the service between July 2018 to April 2019. For a second person, 12 incidents of marks, bruising and scratches had been recorded between July 2018 to February 2019. We asked the management team about these incidents and were told that injuries were usually self-inflicted. However, there was insufficient information available to show that risks had been mitigated adequately. These issues had not been raised as potential safeguarding concerns with the relevant local authority and the CQC in line with the provider's responsibilities under their registration. Due to a lack of thorough and robust investigation, we cannot be assured that people were being protected from avoidable harm.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People using the service were not being protected from improper treatment. We heard staff instructing people to "Come on", "Put your shoes on", "Take your shoes off', "Get up", "Stand up", "Go and have your lunch", "You need to go to the toilet" and "Stop it". Staff appeared unaware that these commands, when used to control and restrict people can constitute a form of abuse.
● Staff confirmed they had completed safeguarding training and when asked, were able to provide some examples of the types of abuse people living in the service might be at risk of.
● Staff assured us they had not witnessed abuse taking place within the home and that if they did, they would report the matter to a manager immediately. However, the incidents of abuse we witnessed were also observed by other members of staff. Therefore, we cannot be sure that safeguarding training provided to staff was effective and/or that staff members fully understood how to safely support people using the service.

Staff behaviour indicated a lack of awareness of what constituted abuse and therefore we could not be assured that people were protected. This constituted a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Preventing and controlling infection

● Areas of the home were not clean. We noted cobwebs on ceiling surfaces, soiled bedlinen in one person's room and furnishings that were ripped and unclean. The front yard was untidy. Rubbish bins were full, and more rubbish bags were stacked on top of the bins. A disused bed frame had been placed in front of a bench blocking access to the only outside seating area. A relative told us that their family member liked to sit outside to watch the world go by. This was not possible at the time of our inspection.

● Staff had access to personal protective equipment such as disposable gloves and aprons to prevent the spread of infections.

Staffing and recruitment

● Recruitment records were held at the provider's main office. We arranged for a sample to be delivered to the service so that we could check that safe recruitment processes were being followed.

● Records demonstrated that the provider requested a minimum of two references for prospective employees and carried out identity checks to ensure that staff had the right to work in the UK.

● Disclosure and Barring Service (DBS) checks were made before any offers of employment were confirmed. The DBS helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were provided with choices at breakfast, but this wasn't always done in a supportive or encouraging manner. For example, we heard a member of staff asking one person, "Do you want Weetabix or porridge, which one?" When no response was elicited, this statement was repeated several times in an impatient manner until a decision was finally indicated.
- One person was due to attend a hospital appointment after having their breakfast. This person's care plan stated, '…. ensure a good fluid intake at all times, a regular and varied daily intake of fluid'. An eating and drinking risk assessment stated, '…. a snack and drink between meals should be encouraged'. We asked staff whether they would be taking snacks and a drink with them for this person. The response was no. This person returned to the home shortly after one o'clock, almost four hours after having breakfast and had been offered neither a drink nor a snack during this time.
- Just after two o'clock, we observed a staff member attempting to support a person with a drink. This staff member called another member of staff for assistance. They proceeded to snatch a cloth this person was holding, then force and hold their hand down. Liquid was then administered without explanation and in an unsafe and hurried manner. We observed the same member assisting with this person's lunch. This staff member sat above the person on the side of an armchair making engagement difficult. They then began spooning food into the person's mouth in a hurried and unsafe manner. This person's risk assessments stated, 'Feed [them] slowly. [They] may need to take short breaks while eating and drinking'. On two occasions we instructed this staff member to slow down. This member of staff responded angrily stating that they were not going too fast and that we did not know the person. Each time the person being assisted raised their hands, this member of staff grabbed them, forced them down and leant on them with their arm to prevent movement whilst continuing to spoon food at a speed that eventually resulted in a bout of coughing. We reported this incident to the management team as an urgent safeguarding concern. The matter is now being investigated by the local authority and the member of staff has been suspended pending the outcome of the investigation.

Risk management plans associated with nutrition were not being followed and people were not always supported with food and drinks in an appropriate manner. This put people at risk of avoidable harm. These concerns constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● People's individual needs were not always being met by the adaptation of the premises.

● One person's recent assessment of support stated, '[Person's name] needs a room equipped with sensory aids and hand rails. Wide hallways, ramps, hand rails and a wet room'. None of these features were currently in place for this person.

● The home had lift access and staff told us they used a mobile ramp for accessing the building. We observed people using wheelchairs entering the building via a side access route past bins containing incontinence waste to enter the back of the building via the kitchen area.

● People's rooms were basic and did not have en-suite bathroom facilities. A communal shower room was located on the first floor. A communal bathroom with a bath was accessed via the kitchen/dining area on the ground floor.

● A sensory room was out of action and unfit for purpose. Staff told us that one person using the service previously used this room as a bedroom.

● Some furnishings and fittings were in need of repair. A ceiling light had no cover and wiring was exposed. Curtain poles were not fixed safely, curtains were old and dirty and a cupboard door was off its hinges. Keys to second floor window locks were accessible to people using the service.

● A vacant room was being used by staff as a sleep over room despite their being an empty staff flat on the upper floor of the building.

● A relative expressed frustration with the delays incurred to plans for refurbishment and redecoration of the home. The regional manager explained that delays had occurred because decant facilities for three people were hard to find.

Aspects of the environment were not appropriately maintained and did not fully meet the needs of the people using the service. These issues constituted a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Initial assessments had been completed and were used to design a package of care for people ensuring their needs could be met by staff at the service.

● Care records contained details of the support people required and included contact details for GPs, family members and other relevant healthcare professionals.

Supporting people to live healthier lives, access healthcare services and support

● People's day to day health needs were managed by the staff team with support from family members and a range of healthcare professionals such as GPs, speech and language therapists (SaLTs), occupational therapists and social workers.

● People's health needs were documented in their care plans along with a record of medical appointments and related correspondence. However, not all information regarding people's current health status was being recorded and updated in people's health action plans.

● Health passports were in place to ensure that important information about people's needs was available if and when they were admitted to hospital.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The provider had contacted the relevant local authority representatives regarding whether people's liberty was restricted, and they required a DoLS assessment.
● People's care records demonstrated that a best interest decision making process was adopted when people required complex medical treatment. Family members told us they were involved in care reviews and contacted by staff for advice and updates as needed.
● An advocate working with people living at Angela House told us that staff appeared to have a very good knowledge of people's preferences.
● Staff told us they offered people choices at mealtimes, with clothing options and activities.

Staff support: induction, training, skills and experience
● Staff completed mandatory training, which included safeguarding, moving and positioning people, health and safety, basic life support, fire safety and food hygiene. However, our observations during the inspection did not always assure us of the effectiveness of this training.
● The manager told us that new staff were required to complete an induction which included elements of the Skills for Care common induction standards which have now been replaced by the Care Certificate.
● Staff told us they felt supported and received regular supervisions.
● Annual appraisals had been scheduled to discuss the roles and responsibilities of staff members and identify any further training needs.

Staff working with other agencies to provide consistent, effective, timely care
● Care records and related correspondence showed that people were supported to access care and treatment from healthcare professionals when needed. This included; dietitians, occupational therapists, doctors, podiatrists, physiotherapists and dentists. However, in some instances, guidance from healthcare professionals was not being followed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

People were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- Staff were not always mindful of or sensitive to people's need for privacy. Access to a ground floor communal bathroom was via the kitchen/dining area and afforded people very little privacy when attending to their personal care. Another ground floor toilet facility was situated directly in front of the main door. This door was not always closed when staff were supporting people with personal care.
- On another occasion we observed a person using the service attempting to remove their lower clothing as one member of staff continued to write notes seated at the same table and another member of staff continued loading a washing machine in close proximity. The situation was only addressed when we stood to observe why staff were not responding to this person's needs.
- The provider was not always ensuring that personal information was stored securely in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. We noted that care records and other confidential documentation was being stored in open plastic bags in an unused room.

We observed that people were not always treated in a dignified way that respected their privacy. These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always supported in a way that seemed respectful to them. Staff told us they encouraged people to engage in activities when in the home. However, some of these activities, such as watching programmes on iPads and playing with dolls and other toys were aimed at children and not necessarily appropriate for adults.
- Despite relatives telling us staff were kind and attentive, we observed very few interactions between staff and people using the service that were kind, caring and respectful.

Supporting people to express their views and be involved in making decisions about their care
- Staff told us that one person using the service preferred to be barefoot when at home. However, this preference may have been unhygienic and unsafe and there was no risk assessment in place to address this risk.
- People using the service were not always able to communicate verbally. Staff told us they used their knowledge of the people they supported, basic sign language and objects of reference to aid

communication.

● A health and social care representative told us, "Staff appear very attentive to the importance of reading how each person communicates non-verbally. With one resident, hand over hand Makaton is being used to try to encourage the person with making choices."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

People's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care records contained information about their support needs in the form of care plans and individual risk assessments. Some information was available about people's life histories, past interests and preferred activities. This information helps staff to understand each person's personality and history and ensures that people are treated as individuals.
- People's care needs were reviewed by local authority representatives, GPs and staff members as required. However, people did not always receive the personalised care that had been planned for them because staff were not always adhering to guidance about how to support people safely.
- A healthcare professional we spoke with told us that people's care and support needs were not always reflected in the day to day care provided.
- Completed monitoring charts provided information about people's changing needs and any recurring difficulties. People's needs were not always described in respectful and sensitive terms.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff maintained daily records of care and entered information about activities people had taken part in. Organised activities included walks and visits to the park, cafes, pub and supermarket. Staff told us that one person attended regular dance and music sessions at a local learning disability centre. Other activities were listed as watching TV, playing with toys, reflexology, massage sessions and listening to music.
- A relative told us that staff regularly sent them updates and pictures of their loved one partaking in activities and days out. However, extended breaks and holidays had not been routinely planned as part of people's lives.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was shared in different accessible formats to promote understanding, for example, using photos and pictures. This showed us that where possible, the provider was complying with the Accessible Information Standard. This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand.

● Care records recorded how people preferred to communicate and how this could be promoted. We observed staff using some basic Makaton to communicate with one person using the service.

Improving care quality in response to complaints or concerns

● Systems were in place to record, investigate and respond to any complaints raised. Family members told us they knew how to make a complaint and to whom. No formal complaints had been recorded since our previous inspection.
● The provider's complaints procedure was available to people using the service, staff and family members.
● People's care records contained a copy of the complaint's procedure in an accessible format.

End of life care and support
● At the time of our inspection no one at the service was receiving end of life care.
● The manager told us that end of life training was not routinely provided to staff members.
● A recent and unexpected death within the service had been discussed during a team meeting. Meeting minutes recorded, 'We struggled to find information relative to funeral plans for [person's name] as we were caught by surprise at [person's name] unexpected passing in December. In order to avoid this situation from happening again, it is important to have end of life plans (funeral plans) prepared for the three remaining service users in Angela House'. These discussions were planned for July 2019.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question had deteriorated to inadequate.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Appropriate investigations did not always follow incidents. We could find no evidence to demonstrate that the provider and manager monitored trends within the service and/or identified specific incidents which required further investigation.
- The provider and service manager had not ensured that we had been notified of all incidents as legally required.

The provider's failure to notify CQC of significant incidents was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were not always supported to have maximum choice and control of their lives.
- The staff team lacked an understanding of how to implement person-centred care that promoted people's health, safety and well-being.
- The management team were failing to correct poor practice when it was observed or to lead by example.
- Whilst the provider had a range of quality assurance systems in operation, these had not always been effective in achieving good outcomes for people. We saw little evidence of a positive staff culture during our inspection.

The provider's failure to ensure people's needs were fully met and good outcomes achieved was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities).

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's oversight and governance systems had not identified the concerns we raised in relation to effective risk management. This put people at significant risk of harm.
- There was no registered manager in post. The current service manager acknowledged that improvements were needed to comply with regulatory requirements. She told us, "It's a struggle. People are used to doing things the way that they want. There's nothing new. We're stuck in the service doing our jobs." The deputy

manager also commented, "I'm confused. We get mixed messages. The mindset is stuck."
● There were systems in place to check the quality of the service including reviewing support plans, medicines, maintenance and health and safety. Where actions were needed these were recorded. However, we found that quality monitoring systems were not always effective and had failed to identify and address the concerns we found during the inspection.

Due to poor governance people were put at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The above issues relate to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were opportunities for people, relatives, staff and visitors to provide feedback about the service via satisfaction questionnaires, team meetings and supervision sessions.
● Improvements needed to the home environment had remained at discussion stage for the past two years. Relatives expressed frustration and concern at this lack of progress.

We recommend the provider consult with appropriate agencies about people's changing and future needs and appropriate plans to meet these needs as a matter of urgency.

Continuous learning and improving care and working in partnership with others
● The manager told us that daily staff handover meetings did not always take place as scheduled. This meant that important information about people using the service was not always being communicated between the staff team responsible for providing their care and support.
● Quality assurance systems the provider had in place to monitor and improve the care and support people received had not been effective in highlighting the failings we identified during the inspection process.
● The manager told us the service had close links and good working relationships with a variety of professionals to enable coordinated care for people. This included healthcare professionals such as GPs, psychiatrists, therapists, clinicians and social care practitioners.
● Relatives and health and social care professionals reported no major concerns with people's care. However, a healthcare practitioner informed us that the staff team was not always consistent due to frequent changes in management and the use of bank and agency staff with this having a negative impact on the care provided.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider must notify the Care Quality Commission of any important event that affects people's welfare, health and safety so that where action is needed, action can be taken. Regulation 18 (1), (2) (e) (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always being met appropriately. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who use services were not being treated with dignity and respect Regulation10 (1) (2) (a - c)

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 who use services and others were not protected against the risks associated with improper treatment and abuse Regulation13 (1) (2) (3) (4) (a - d) (5) (6) (a - d) (7) (a - b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises Regulation15 (1) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place were ineffective and failing to monitor and improve the quality of the service. Regulation17 (1), (2) (a - f)

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or inappropriate care and support. Regulation12 (1) (2) (a) (b) (c) (d) (g)

The enforcement action we took:

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