Potensial Limited

Avondale Lodge

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 well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 13 June 2018 at 06:30 and was unannounced. This meant the provider did not know we would be visiting. We attended the service early because we needed to review staffing levels at night and review the number of people up early in the morning.

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

Avondale Lodge provides care and accommodation for up to 12 people who live with a learning disability. At the time of our inspection there were 10 people using the service. The service consists of two Victorian houses which have been adapted to become one building and is situated in a residential area of Redcar, close to the sea front and local amenities. People have their own bedrooms and access to several communal areas. There are gardens to the front of the service and two small courtyards to the rear.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was no registered manager in post at the time of inspection. Two external consultants had been in place since 21 May 2018 and were expected to be in post until 29 June 2018. The provider told us a manager from another service in their portfolio would be in place from 21 June 2018 and they would submit an application to become registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was rated 'Inadequate' following inspection on 15 and 18 August 2017. There were concerns relating to all areas of the service and we identified multiple breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We imposed conditions that required the provider to ensure the registered manager was competent to work at the service, staff had the necessary skills to effectively use positive behavioural support interventions and that there were sufficient staff on duty. The provider complied with these conditions.

We carried out a further inspection of the service on 19 December 2017 following concerns received in relation to the safety of people using the service and the overall quality of the service. Although we found improvements were being made, the service continued to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service continued to be rated 'Inadequate.'

At inspection on 20 March 2018, we found the service had made significant improvements. There were still further improvements to be made, however the peripatetic manager in post was aware of these and plans were in place for these to be addressed. We removed the conditions which we imposed. We contacted the provider following the inspection and told them they needed to continue with the improvements to be rated Good. We also told them that they needed to have a registered manager in post.

At this inspection, we found that the improvements identified in March 2018 had not been sustained. There was evidence of further deterioration at the service.

There were insufficient staff on duty at all times. People did not receive all of their one-to-one care.

Staff were not following the provider's policies and procedures because incidents were not always recorded or reported; one person told us about how watching another person hurt themselves caused them distress. Risk assessments did not contain accurate and up to date information. Staff were not routinely working in a way which minimised the risk of harm to people.

There was a lack of transparency about the use of one person's car. Financial records had not been accurately maintained and it was impossible to determine if people were reimbursing the person when they used their car. We asked the provider to raise a safeguarding alert which they did. This alert was upheld for financial abuse.

Improvements were needed in the management of infection prevention and control. Water temperatures were outside of safe temperature levels.

Staff did not routinely manage the risks to people from malnutrition and choking. Regular checks of weights were not carried out and staffing levels impacted upon mealtimes. Further improvements were needed to the environment. Staff had not been supported through their induction or by way of regular supervision. Not all training was up to date. People were involved with health and social care appointments and were routinely invited for screening appointments.

People were not always supported to have choice and control of their lives and staff did not always support them in the least restrictive way possible. Staffing levels were insufficient to enable people to engage in meaningful activity and have a full range of choices. People's monies were spent without consultation or best interest decisions taking place. Staff had not followed the policies and systems in the service. Staff had not worked in line with the Mental Capacity Act 2005.

Care records needed further information to support staff to deliver care which was in line with people's needs, wishes and preferences. People did not have access to regular meaningful activities.

The consultants in place during inspection did not assist staff when they were struggling to meet people's needs.

Since the last inspection, the culture of the service had changed. A divided team was in place and morale was low. Staff had not been raising concerns because they had not known who to raise concerns with.

The provider and consultants had carried out audits at the service which were designed to drive improvement. We found that there were delays in addressing the actions identified. Audits carried out by staff were not effective. The quality of record keeping needed to be improved and some records needed to be archived. Staff were not always following the policies and procedures at the service and were not using

the audit tools and outcomes to drive improvement.

There was a lack of understanding about which incidents staff needed to report. Safeguarding alerts were raised with the local authority, however actions identified during safeguarding meetings had not always been fully addressed.

The provider had completed an extensive lessons learned exercise following the findings from inspection in August 2017. An action plan was in place and had been updated when actions had been addressed. Notifications had been submitted without delay. The service continued to have links with their local community.

We found multiple breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to requirements relating to registered managers, person-centred care, safe care and treatment, safeguarding people from abuse, the premises and equipment, good governance and staffing.

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 is 'Inadequate' and the service is placed in 'special measures for a second time within 12 months.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risk assessments were not always accurate or effective. Incidents were still not routinely recorded.

There were insufficient staff on duty. People did not receive planned one-to-one hours.

Some water temperatures were outside of safe temperature limits. Infection prevention and control procedures were not maintained.

There was evidence of financial abuse. Best interest decisions had not been carried out in relation to people's monies.

Is the service effective?

Requires Improvement

The service was not always effective.

Induction, training and supervision had not always been carried out.

People at risk of malnutrition and choking were not consistently supported. People received their breakfast late because of inadequate staffing levels.

The service remained in need of updating. People did not have access to suitable outside space. Flooring need to be replaced. Damage to walls, woodwork and furniture needed to be repair or replacement.

Is the service well-led?

Inadequate

The service was not always well-led.

The provider had not maintained the improvements noted at inspection in March 2018. There was no registered manager in post. Staff told us the staff team was divided and they were struggling with the continued changes taking place.

Audits were ineffective at monitoring standards and driving

improvements.

Staff did not have a key staff member within the organisation to raise concerns with. This meant incidents continued not to be recorded.

Avondale Lodge

Detailed findings

Background to this inspection

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

Two adult social care inspectors carried out an unannounced inspection of the service at 06:30 to enable inspectors to speak with night staff.

We had previously carried out a comprehensive inspection of this service in August 2017 in response to two alleged incidents which took place at the service. The Commission made a decision under its own Handling Serious Incident Guidance, that it was necessary for it to attend the service and make inquiry into the incidents, as well as to assess the risk and compliance to people using the services. We rated the service to be inadequate and placed the service into 'special measures.' We imposed conditions in relation to minimum staffing numbers and staff competencies.

We carried out a focused inspection in December 2017 because we received concerns in relation to the safety of people using the service and the overall quality of the service. The service continued to be rated inadequate and remained in 'special measures.'

In March 2018, we found significant improvements had been made across the service. As a result we rated the service to be 'Requires improvement' and removed the conditions which we imposed. The service was no longer in 'special measures.'

Before our inspection we reviewed all the information we held about the service. We examined the notifications received by the CQC. Notifications are reports about changes, events or incidents that the provider is legally obliged to send us within the required timescales. Since the last inspection we had attended serious concerns protocol meetings with Redcar and Cleveland local authority which included health and social care professionals involved with the service. We used the information from these meetings as part of our inspection planning.

During the inspection we spoke with three people. We also spoke with an external consultant, deputy manager, one carer and an agency member of staff.

We reviewed three care records in detail and all of the 'crib' profiles. The 'crib' profiles provide an outline of all the care a person needs and how this is to be delivered. We reviewed two recruitment and three induction record and six supervision and appraisal records. We reviewed the training summary records for all staff. We also reviewed records relating to the day to day running of the service.

We looked around the service and went into some people's bedrooms (with their permission) and visited the communal areas. We carried out observations of practice and a specific observational framework for inspection (SOFI) to capture the experiences of people who could not communicate with us.

Inadequate

Is the service safe?

Our findings

At a previous inspection in March 2018, we found the provider had addressed the concerns which we identified during inspections in August and December 2017. There were some improvements which were still needed to maintain the safety of people and staff. During the inspection, we highlighted that doors which were required to be locked for safety were left open. The gas boiler and electrical wiring in the staff toilet was accessible and had not been boxed in for safety. Bathing temperature records showed that people were routinely bathed in temperatures below 38 degrees Celsius. We were assured by the peripatetic manager in place at the time that these issues would be addressed.

At this latest inspection we found that many of the issues had been addressed. Doors which were required to be locked for safety were locked and action had been taken to box in the boiler and electrical wiring in the staff toilet. However, improvements were needed to manage infection, prevention and control at the service. The seal and laminate around the kitchen sink had become worn. Not all carpets were clean. The cleanliness of the service overall required improvement. Grouting was missing in some areas of tiling. A cupboard in the hallway which contained electrical wiring had not been made secure.

Water temperatures recorded during inspection were too low in some communal areas and did not support people and staff to maintain good hand hygiene. The kitchen sink and hand washing sink in the activities kitchen were recorded at 17 and 20 degrees Celsius and the sink in the staff toilet was recorded as 19.7 degrees Celsius. Water temperatures in the kitchen, which people used during activities of daily living, were too hot. We recorded temperatures of 47 degrees Celsius in the hand washing sink. No safety signage was in place to alert people and staff to hot water and no risk assessments had been carried out to determine how the risk of hot water to people would be managed. This increased the risk of harm to people through burns and scolds. We spoke with the consultant and they told us they would take immediate action to address this.

We asked staff on duty when we arrived for the personal emergency evacuation plans (PEEPs) for everyone using the service. These are records which provide emergency services with information about people, such as assistance required to leave the building and important medicines. These records were not accessible because they had been locked in the manager's office and staff did not have a key to this office.

Risk assessments and care plans did not always contain accurate and up to date information. For example, in one person's mobility care plan the record stated they are subject to continuous supervision and this reduced their risk of falls. This information was incorrect. The person was not subject to continuous supervision. They had 35 hours per week for on-to-one support, however they had not been receiving these hours. This meant staff were not routinely monitoring and reviewing the risk of falls to this person. A communication record for this person stated they did not show anger or boredom. We questioned the accuracy of this because these are human emotions.

The care records did not support staff to provide safe care and support in line with people's individual needs. This caused concern because new staff had started working at the service and agency staff were

working at the service at the time of inspection who were not up to date with people's individual needs. We could see that staff did not have sufficient time to review and update these records. The provider had not allocated additional staff hours to dedicate to records.

The provider allocated time in staff meetings to discuss lessons learned with staff. At inspections in August and September 2017, we identified staff were not reporting or recording incidents taking place at the service and as a result people and staff suffered abuse. At this inspection, we found staff were not routinely reporting or recording incidents, such as when people caused harm to themselves through biting their skin or when people displayed behaviours which challenge. During inspection, one person described how they became upset watching another person bite themselves. The person told us, "They did not like this," and "It made them feel sad." Although the provider had systems in place, staff were not following the correct procedures to keep people safe from harm and abuse.

Some people using the service could display behaviours which challenge. On the day of the inspection, we found there were insufficient staff on duty to provide support to one person who could display these behaviours. Staff told us that this person needed two members of staff when behaviours which challenge were displayed. Of the three members of staff on duty from 10:00, one staff member could not assist this person for safety reasons and another member of staff was male and had never supported this person before. No action had been taken to assess the potential risk of behaviours to escalate or to review staffing levels and the staff in place to best meet this person's needs. This left one staff member to support this person.

Overall, there were not enough staff on duty to provide people with safe care and support. At 08:00 there were two staff on duty to support ten people, some of whom required one-to-one support with personal care. This increased the risk of potential harm to people.

At 09:00 one member of staff left the building with three people to take them to a local day centre. Three people had already left in private transport to another day centre. This left an agency member of staff with four people in the building, two of whom were asleep and one of whom required support from two staff members. When we spoke with the agency member of staff, they incorrectly told us there were only three people in the building. We were concerned about this because it potentially compromised the safety of people using the service.

In addition to funds received from the local authority to live at the service, nine of the ten people using the service received additional funding for one-to-one hours each week. These one-to-one hours were used to support people with activities, such as swimming, going out into the community, activities of daily living or attending appointments. We reviewed staff rotas, care records, spoke with staff and carried out observations and determined people were not receiving their planned one-to-one hours. One staff member told us, "One-to-one's haven't been getting done because there isn't enough staff."

One person was on the rota with scheduled one-to-one hours on the day of inspection. We observed that this person did not receive them because there was not a staff member available to provide them. A staff member told us that the hours would be used later in the day when more staff were available. The hours were to be used to take the person to a healthcare appointment. Staff had not considered whether the person might wish to spend time in the community to use all of their one-to-one hours. No plans had been made about how to use this person's one-to-one hours.

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

We carried out observations during inspection and identified that the two staff on duty between 08:00 and 10:00 did not have the resources needed to support people with all of their needs. Breakfast time was rushed because the deputy manager needed to prepare and support people with breakfast, whilst dispensing medicines and answering people's questions. The agency care worker was assisting people to get up. During this time, there was no staff member available to sit with people and engage them in conversation or respond to their requests.

One staff member returned to work on the day of inspection following a period of sick leave. They were due to start work at 10:00 and allocated on the staff rota to deliver one-to-one care. The staff member arrived at 09:30. The external consultant providing managerial support took this staff member into a meeting at 09:40 to carry out a return to work interview. This meeting finished at 11:10. During this time, no additional staff were provided to support the deputy manager and agency care worker. The deputy manager had not been made aware that this staff member was on-site. Whilst this meeting took place, the agency carer took one person out leaving the deputy manager with three people. One of whom required two staff and another of whom was on the rota to receive 1:1 care.

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

We saw that staffing levels impacted upon the care and support which people received. For example, staff did not have time to sit with people or participate in an activity with them. People were left watching the television because staff were busy trying to meet the demands of the service. People waited longer than they needed to for care and support.

The lack of staffing meant staff missed opportunities to provide support to people when they became upset. We observed one person displaying stimming behaviours. These are repetitive behaviours which are used to stimulate a person's senses. The person also repeatedly said they wanted to go out. There were no staff in the area during this time for staff to respond to this person's needs. There were insufficient staff on duty at this time to take the person out as they had requested. This had gone unnoticed by the provider.

One person had a healthcare appointment, and although planned one-to-one hours were in place, staff planned to take the person to their appointment and return to the service without using all of the one-to-one time because there were insufficient staff on duty. This was another missed opportunity to provide meaningful activity to this person.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person using the service had their own car which staff were allowed to use to transport the person to appointments or out into the community. Staff told us that an informal agreement was in place with the person's relative which enabled other people to use the car at the same time as this person as long as the journey involved a place of mutual interest. An agreement was in place about how much other people needed to contribute to the cost of petrol to minimise the risk of financial abuse to the person who owned the car. We found no evidence of these agreements in the person's care records and were informed at a safeguarding meeting that the relative had not agreed to the use of the car for others.

In the available records reviewed, we found that information about when the car was used was not clearly recorded. No one recorded accurately when people used the car and the financial records for people did not show corresponding information about the petrol money being paid. Not all of the payments for petrol were

recorded and not all of the transactions were detailed. This meant information about who used the car, for what purpose and the cost incurred was not accurately recorded.

We asked the provider to make an immediate safeguarding referral to the local authority which they did. This alert was upheld for finance abuse. A best interest decision took place and a decision was taken to return the person's car to avoid further financial abuse.

We saw one person was using the car to visit a relative. The person who the car belonged to went on the same journey, but went into the local town to wait for the person to carry out their visit to their relative. There was no evidence in place to show that the person who the car belonged to wanted to go or if the place visited was of interest to them. Staff could not tell us what this person did whilst waiting in the local town. There was no evidence to show the person who owned the car received any payment for petrol. We determined this was not in-line with the person's interests.

We also determined that this person's car was used generally to transport people in the local community. Staff told us that the car was used in bad weather to take people to their day centre. Staff had not considered that this was abusive practice.

Staff did not manage people's monies safely. This had led to financial abuse. In addition, staff also spent people's monies without consultation. For example, staff purchased a second wheelchair for one person using the person's monies. The person had not been assessed for this specific wheelchair and when checked it had not been found fit for use. Since this concern was raised the provider reimbursed this person for the cost of the wheelchair.

A financial audit of people's monies had been carried out prior to inspection, however it failed to identify any of these concerns and was therefore not fit for purpose.

People were not safeguarded from financial abuse because staff did not follow the correct procedures. There was no evidence that best interest decision making had taken place when spending people's monies.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to medicine records and the storage of medicines. The practices in place could lend themselves to future medicines errors. Medicines liable to misuse had been inconsistently recorded. Medicines had not been routinely dated once opened and protocols were not in place for all 'as and when required' medicines.

Prior to inspection, the provider had asked their local prescribing pharmacy to carry out a review of medicines at the service with the aim of improving medicines management. The regional director told us after inspection that this visit had gone well. Some recommendations were in place and the pharmacy were due to review again in three weeks. As part of the support offered by the pharmacy, staff were undertaking further training in medicines as part of their development.

The area manager contacted us after inspection to tell us that an office had been converted into a medicines room. This action allowed more space to store and manage medicines, improved infection, prevention and control measures and privacy for people to access their medicines.

Recruitment records were in place. This showed the provider followed their own policies and procedures to

recruit candidates safely. Up to date health and safety certificates were in place. Staff had participated in planned fire drills and records to support fire safety were up to date.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in March 2018, we saw that improvements had been carried out and plans were in place to make further improvements. At this latest inspection, we found they had been delays in making improvements to the environment because the maintenance team were needed elsewhere and the improvements found in nutrition and staff supervision, induction and training had not been sustained.

People at risk of choking and malnutrition were not robustly and continually supported. For example, an eating and drinking care plan for one person stated they had been discharged from a speech and language therapy team (SALT) in August 2016 with recommendations in place. These recommendations suggested the person required bite size pieces of food which could be mashed with a fork.

We observed this person was given toast and banana for their breakfast, yet staff could not tell us if this person could eat bread. This meant staff were not aware of the recommendations and guidance in place to support this person safely. We also observed that food was presented on a plate when recommendations said to use a bowl.

The care plan stated that the person was at risk of malnutrition and illness if they did not maintain a healthy weight and that staff should document the person's food intake and weekly weights. The care plan did not indicate what a healthy weight was for this person which meant staff could not accurately review the risk and did not include information about the action which staff needed to take if the person lost weight.

Staff were not following the care plan for this person. This person had not been weighed weekly. We noted this person had lost 3.5 kilograms between 25 January 2018 and 2 June 2018. Specifically, a 2.5 kilogram loss had occurred between 22 April and 28 April 2018. No action had been taken to address this. We determined that staff were not aware of the risks to this person and had not read the care plan or the reviews.

We observed that this person was not supported appropriately at mealtimes. This person was given a fortified drink at 08:40, however, they did not receive their breakfast until 10:40 because of inadequate staffing levels. This person was assisted to eat their breakfast by a member of staff, however this was interrupted because the staff member needed to go and answer the door.

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

Further improvements were needed at the service to make the environment suitable for people using the service. For example, the two courtyard areas at the back of the service were not accessible. The ground itself was not level. The courtyard areas contained a car, rubbish and clutter. There were no accessible areas for people to relax. The garden areas to the front of the property needed to be maintained. At the last inspection, we were told planned work was in place to improve these areas and a project was planned for people to have flower beds and a herb garden. Neither of these were in place at this inspection.

Internally, repairs and improvements were needed in many areas. Flooring in a hall way needed to be replaced. Some skirting boards and walls were damaged. Paintwork in many areas needed improving. In the bathroom, a ceiling plastered in January 2018 had not been painted. In the kitchen, an oven and extractor fan were broken. The leatherette on the sofa in the lounge was broken. In bedrooms, beds and furniture needed to be replaced. Many of these issues had been identified at the last inspection and during the provider's most recent audits, however timely action had not been taken to address them. After inspection, the provider told us that the maintenance team were at the service working on the improvements needed.

There was no hoist in place at the service for five people who needed support to access the bath. This lack of equipment meant people did not have a choice because only a shower was available to them. After inspection, the provider told us the hoist had been removed because it was no longer safe to use and referrals to occupational therapy and physiotherapy service had been made to reassess people to use the bath. Timely action had not been taken to replace the hoist which was no longer fit for use. This impacted upon people's choices.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed three staff records and found staff had not received their induction in line with the provider's policy. For example, one staff member had completed their two-day induction but had not received any reviews over the 12-weeks of the induction. A second staff member did not have any completed records to support their induction and a third staff member had completed their 12-week induction and probationary period in five weeks.

Supervision and appraisal was not up to date for staff. A small number of appraisals were outstanding and staff had generally not received the number of required supervisions in line with the provider's policy. We found the latest supervision sessions which staff had participated in with the consultants was thorough. Not all training was up to date. The provider had responded to a recent manual handling incident and all staff had completed e-learning as a preventative measure, however this did not include a practical element of training.

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

The provider had recognised that dysphagia training not in place and had taken action to source training and were awaiting a confirmation date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff did not always work with in the principles of the principles of the MCA. There was a lack of understanding about MCA. Best interest decisions were not always carried out, particularly in relation to people's finances.

People's healthcare needs were assessed. Best interest decisions had been carried out when people had been invited to participate in health screening. Healthcare professionals were involved in supporting people with all aspects of their health and recommendations had been included into care plans, though these were not always followed by staff.

One person's relative had wanted a person to move to another service. Staff had taken appropriate action to involve the relevant health and social care professionals to make a decision about what was in the person's best interests. Records were in place to show the progress which had been made and staff were able to provide a detailed overview of this during inspection.

Inadequate

Is the service well-led?

Our findings

The service had not sustained the improvements identified at the last inspection in March 2018.

The peripatetic manager had left their employment at the service at short notice. In response to this, the provider put an emergency plan in place. This included assistance from a consultancy agency during this interim period whilst a registered manager from another service within the provider's portfolio started working at this service. This action allowed the new manager to have a transition period and allowed people using the service and staff to get to know the new manager. A senior manager also visited the service twice per week to carry out quality monitoring of the service.

Two consultants were in place and shared the role to provide managerial support over five days each week. The consultants carried out audits and supervision with staff. However, they did not provide hands on support to staff when staffing levels were low or when staff were struggling to cope with the duties expected of them. The consultants had not considered how their own actions had contributed to inadequate staffing levels. For example, they were in the building when staff were visibly struggling to meet the demands of people yet no action had been taken. They had undertaken a return to work interview lasting one hour and 30 minutes without forward planning or acknowledging that this impacted upon staffing levels and a failure to deliver planned one-to-one care.

The culture of the team had changed since the last inspection. Staff told us the team was 'divided' and were generally not supportive one another. They also told us morale had decreased. Since the last inspection, staff had not raised concerns when they needed to. This included inappropriate behaviours by staff towards staff. When we spoke with staff, they told us they didn't know who to raise these concerns with, but also questioned how this had gone unnoticed by the provider. The provider did not have a key staff member in the organisation with whom they could raise concerns with.

There was a lack of administrative support at the service to assist the management team with archiving records. For example, during our review of staff records, we found records for staff who no longer work at the service. We also identified records had not been updated when changes have been made. For example, we were shown a 'Current development plan' for the service, however we found the information was outdated. The plan referred to a member of the management team who was no longer employed by the provider and CQC conditions which were no longer imposed upon the provider's registration.

There were gaps in the information in some records completed by staff, for example, safeguarding records did not always include the action taken by the service to minimise the risk of reoccurrence. Records for medicine errors had a general lack of information. This lack of information did not allow the provider and staff to carry out analysis to minimise the risk of reoccurrence.

Improvements had been made to the auditing system. Audits carried out by staff did not identify the same level of improvements as those carried out by the senior management team and consultants because they had not been completed critically enough. The audits carried out by the provider and consultants were

thorough and had identified many of the same concerns identified during this inspection yet the improvements found at the last inspection have not been maintained. In the audits, the records show that some concerns had been repeated in each audit, such as improvements needed to the environment. There were areas which were not identified. For example, staff had carried out checks of water temperatures, which were outside of safe temperature limits. Staff had not raised this with the provider.

There were delays in the actions from audits being addressed. This meant timely improvements were not carried out. For example, an infection prevention and control audit carried out 30 May 2018, scored 57%. No action plan had been put in place. The audit was in the manager's office and asked all staff to read though and sign the audit. Although some staff had signed this audit to show they had read and understood it, it was clear during inspection that they had started to action the improvements needed, such as with the cleanliness of the service. The audit stated that delegation would take place at the next staff meeting on 29 June 2018. This showed that actions were not immediately addressed.

No checks of care plans had taken place along with observations of practice to determine whether staff were following the actions identified within them. As identified during this inspection, staff are not consistently managing the risks to people and are not always following the provider's policies and procedures.

A financial policy was dated June 2011 and was due for review in June 2014. The policy did not show if it had been reviewed on this date and no reviews of the policy had taken place since. At the time of inspection, the provider told us this policy was under review.

It was very apparent during inspection that people were not receiving their one-to-one care, yet the provider had not carried out any of their own analysis. The provider failured to maintain the improvements found at the last inspection.

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

A registered manager had not been in post since 11 January 2018. After inspection in March 2018, we contacted the provider and informed them that a registered manager must be in place. They had taken action to address this, however the manager in place at that inspection had left the service. A registered manager from another service within the provider's portfolio started at the service shortly after the inspection and submitted an application to become registered manager of this service.

This was a breach of regulation 7 (Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC of deaths and other important events that happen in the service in the form of a 'notification.' The peripatetic manager had completed these notifications when needed.

The provider shared a very thorough lessons learned record, dated 22 February 2018 with us which examined the findings from inspection in August 2017. The record showed an extensive review of records had been carried out and significant discussion had taken place. The record included a list of action which the staff involved in the exercise felt needed to be carried out to improve the overall quality of the service and minimise the risk of reoccurrence of similar events from happening again.

The service had links with the local community. We saw that people regularly visited their local community and staff told us that people using the service were well known in the community. The provider and staff have continued to work alongside health and social care professionals during visits and meetings.