National Schizophrenia Fellowship

The Mead

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Mead is a care home that provides accommodation to six people with mental health care needs. At the time of the inspection five people were living at the service. 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.

A registered manager was not in post and the recruitment process was is in place to employ a registered manager. A service manager with day to day management responsibilities was appointed on 15 January 2018. 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.'

Staff told us there had been five changes of managers in 12 months. While staff said they "held the home together" during this period, the records showed they were not knowable about fundamental standards, how to introduce changes of legislation and partnership working. For example, enabling people and working with regulators.

There were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who used the service. However, these systems were not fully effective as they failed to identify the shortfalls in all areas of service delivery. Where shortfalls were identified and action plan were devised the progress made on the improvements were not monitored.

Safeguarding processes were not always followed by the staff because when people made allegations of abuse the staff had not reported them to the lead authority in safeguarding. The staff told us and training matrix showed staff had attended safeguarding of adults training. Their comments indicated they knew how to recognise the types of abuse and their duty to report abuse. However, when people asked staff not to report allegations of abuse, the staff had not reported the allegations. The head of services said their instructions to reporting these allegations were not followed. This meant a multidisciplinary meeting to discuss strategies with the person did not take place and opportunities to establish the appropriate support were missed.

Risk management systems were not robust and placed people at risk of potential harm. Individual risks to people included exploitation, addiction, self-harm and eating disorders. While risk assessments detailed how people viewed the risk. Action plans were not in place on managing individual risks or on supporting people to take risk safely. There was a lack of clarity on the staff's responsibility to update records. Safety management plans that accompanied the risk assessments were poorly completed and lacked guidance for consistency and to keep people safe from potential harm. Where there were potential risks to others risk assessment were in place. For example, the symptoms of a deteriorating mental health or the actions from staff to protect other people from harm such as distraction techniques and moving people from the vicinity.

Where there had been incidents of self-harm risk assessments were not reviewed or updated. We saw there had been an investigation following the reporting of some incidents. There had been a post incident discussion with the person but no further action was taken to minimise the risk.

Staff were not given guidance on consistently administering medicines prescribed to be taken "as required" (PRN). The medicine procedure gave direction for staff to develop "As and When required medication plans." Medication plans were not developed for PRN medicines prescribed for pain relief, depression and to reduce anxiety. This meant PRN protocols were not developed on how staff were to recognise when people might need these medicines.

The staff were not supported to develop the appropriate skills and knowledge needed to meet the needs of people accommodated. The training matrix showed that not all staff were trained in mental health care awareness. For example, records showed one member of staff had attended mental health awareness training in 2016. Two staff had not attended this training since 2010. Another had not had any training in this area. Specific eating disorder training, addiction to drugs and alcohol training was not provided to staff although people were accommodated with complex mental health care needs. This meant staff were not up to date with current practices.

People accommodated had capacity to make complex decisions. Consent was signed by people to share information, photographs and for the administration of medicines. The training matrix showed staff had attended training in the Mental Capacity Act (MCA) 2005. Conversations with staff indicated gaps in their understanding of the principle of the act. Where complex decision were to be made staff did not participate with enabling or empowering people to reach these decisions. For example, giving people informed choices or discussing the consequences of unwise decisions.

There was an expectation that people self-cater their meals. The staff told us people prepared weekly menus and were provided with a weekly budget for food shopping. A member of staff said there was some support with testing recipes if requested. The self-catering procedure stated that "service users complete a weekly menu planner supported by staff if required. This will detail what meals the service user is planning to eat for the week and ingredients needed. This is an ideal opportunity to discuss menu ideas and healthier options." Menu plans in place did not follow the procedure and were brief and incomplete. For example, olives were the only item recorded for lunch on one day. Menus did not show people were being supported to maintain a balanced diet. Also one person was not developing menu plans and there was little evidence to show staff were supporting this person with healthy eating.

Some systems did not provide people the opportunity to receive person centered care. For example, where staff administered medicines people were not asked about their preferences on where their medicines were to be administered. People had to go to the office for their medicines.

Support and safety management plans did not fully reflect people's physical, mental, emotional and social

needs. The agreed outcomes specified within social workers comprehensive care plans were not used to develop with the person support plans. Staff told us they followed the "Integrated Support and Safety Planning" procedures. They said risk management plans for risks were developed once discussions and agreements were reached with the person. People were also given the opportunity to set goals and with staff support to measure and review goals. Where people refused to develop action staff did not help them understand their care and treatment needs.

People's records were securely stored. They were password protected and protocols were in place for staff including bank and agency for accessing relevant records. Some records were not complete and information was not detailed. On the first day of the inspection we were given hard copies of the support and management plans and staff confirmed these records were the most up to date copies. On the second day we were told there were more up to date records and these were online. On the third day we were told a management system was used to record support plans which gave access to senior manager to review the plans in place. This meant the records covered on first day had to be reviewed on subsequent days.

People were supported to self-administer their medicines. One person told us a lockable space was provided in their bedroom for the safe storage of medicines. They said an assessment of their competency had taken place and there were checks by the staff to ensure medicines were taken correctly. Competency assessments records completed by the staff detailed people's ability to continue with self-administration of medicines.

Staffing rotas were designed for higher staffing levels during the day. Two staff and the service manager were on duty until 5pm and from then onwards there was lone working. There was no waking staff available to people from 10:30 pm onwards but can be woken if an incident occurs. This meant the deployment of staff restricted opportunities for people to participate or join evening activities within the community with staff if requested. For example, clubs. The service manager said staff are committed to work flexibily as required.

Steps were being taken to improve how staff were to support people develop and progress to independent living. An overarching improvement plan was devised by the head of services on themes identified within services. A further plan was develop by which complimented the homes improvement plan devised by the service manager. The service manager told us they had made a commitment to develop safeguarding processes, one to one supervisions with staff and the management of risk.

Staff told us the team was stable and they worked well together. They told us that since the appointment of the head of services and service manager improvements had taken place.

The staff told us arrangements to discuss their performance and personal development was in place. They told us since the appointment of the service manager one to one meetings had happened. A member of staff said the service manager had made them aware that "there will be reflective practice" which showed there will be opportunities for continuous learning.

We saw people seeking staff attention and reassurance. Staff supported people when they became distressed and responded to requests for support and assistance. Staff knew people's preferences and how to approach people in a sensitive manner.

One person told us the staff had supported them to seek voluntary employment and to move into independent living accommodation. This person also told us the staff respected their right to privacy and were provided with keys to the home and to their bedrooms.

You can see what action we told the provider to take at the back of the full version of the report. We found breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made a recommendation on medicines.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risks were identified but action plans were not developed on how staff were to support people to take risk safely and to minimise risk. Members of staff were knowledgeable about the risks but not on the actions necessary to reduce risks.

People said they felt safe. However, safeguarding procedures were not always followed. Staff had attended safeguarding adults training and their comments indicated they knew how to recognise the types of abuse and their duty to report their concerns. Their understanding of confidentially in relation to reporting safeguarding concerns was inconsistent.

Medicine systems were mostly safe. Staff had signed medication administration records to indicate the medicines administered. Procedures on the administration of when required medicines were not in place.

There were sufficient staff to support people during the day and we observed that staff were visible and available to people during these periods.

Is the service effective?

Requires Improvement

The service was not effective.

People were able to make complex decisions. There was little evidence to support that people were given informed choices.

The staff had not attended training relevant to the needs of people at the service. One to one meetings with the service manager were organised to discuss performance, concerns and training needs.

People were not supported to develop menu plans that promoted healthy eating or to make healthy choices.

Is the service caring?

Requires Improvement

The service was not caring.

People were not helped by the staff to understand the purpose of CQC inspection which meant some people refused to give their feedback.

Two people said the staff were caring and this was achieved by having one to one time with specific staff.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Requires Improvement

The service was not responsive

People were not helped to understand the care and treatment choices available. People were not supported to reach informed decisions on specific courses of treatment.

Support plans were person centred and while the person's ability to meet their identified need were detailed, support plans were not in place for all identified needs.

Some systems did not give people opportunities for person centred care.

People were not supported to take part in activities that were relevant and appropriate to them.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of understanding on the scope of registration and how to apply them to achieve the aims of the home.

A registered manager was not in post and staff said there had been five changes of manager in 12 months.

Quality assurance systems were not being used effectively. There were arrangements in place for continuous improvement and learning.

Staff were aware of the values of the organisation and said the team was stable and worked well together.

The Mead

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.

Before the inspection, we also used information the provider sent us in the Provider Information Return to plan this inspection. 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. We also reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required. Some of the information received was in relation to procedures which placed people at risk of harm. For example, the procedures on how to access emergency treatment and the assistance staff were to provide to people who were placed at risk of harm in the community.

The provider was not meeting all Fundamental Standards and we imposed requirement orders on four breaches of regulation. We discussed our concerns with the Head of Services and we asked them to reassure us on how people's safety was to be promoted. We provided written feedback at the end of the inspection on the concerns identified at the inspection. Copies of the improvement plans devised by the Head of Services were provided and were based on how outcomes were to be improved. For example, reviewing support plans more regular one to one meetings with staff and introducing more robust quality assurance systems.

This inspection took place on 24, 25 and 31 January 2018. The service manager was aware of the visit arranged for the second day of the inspection. At the time of the inspection there were five people living at the home.

The inspection was carried out by one inspector. We spoke with two people and two others refused to give

feedback. We also spoke with three staff, the service manager, interim manager and head of services. We spoke to one social worker and made attempts to speak with two other social workers and commissioners of placements. However, these professionals did not respond to our request for information about the service.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included three support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Our findings

Systems were in place to monitor any safeguarding referrals that were made however; these systems were not always effective. Staff told us and the training matrix showed that staff had attended safeguarding adults training. Staff told us that they knew how to identify the signs of abuse and about their duty to report concerns. However, one person at the home had told staff of a serious incident that occurred while they were in the community. This person told staff that they did not want the matter to be referred to the police. Whilst the person had capacity to make this decision, the staff were not aware that they had a duty to report concerns of abuse to the local authority safeguarding team in order that the incident could be considered and support offered to help the person keep themselves safe.

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

Despite people telling us they felt safe the risk management systems were not effective. People were not protected from potential harm or supported to take risks safely. Staff completed safety assessment forms to record the risks to people. Where risks were identified as medium or high, a safety management plan should be developed. Staff had documented that during periods of deteriorating mental health there was a risk that people or others may be at risk of harm. While some staff were able to tell us the strategies used to keep people safe the safety management plans were not clear. The plans did not include the signs of deterioration and how staff were to respond to the risk.

One person was at risk of poor nutrition, as they did not eat a balanced diet during times of poor mental health. A member of staff told us these behaviours were "coping strategies" that reflected the person's emotional state. A safety management plan on how staff were to support the person was not in place. This meant there was not a consistent approach to support this person and staff may not have been clear on the person's deteriorating mental health. We were not assured that appropriate referrals were made to healthcare professionals to provide staff with additional advice and to support the person maintain a healthy diet during these times.

A social worker had provided details of the safety precautions that staff needed to implement "to minimise further self-harm" for one person. A safety assessment plan was not devised, by staff, on the safety precautions identified by the social worker. A member of staff said all "sharps" objects were kept locked in the office and there were daily checks of "sharps" objects kept in the office. However, the staff had not

introduced or assessed the risk of all checks requested by the social worker. Staff had not considered how having all "sharp" objects locked in the office impacted on other people within the home. This meant people at the home had restricted access to cooking utensils.

Staff had documented one incident of a person self-harming. The head of services had investigated this incident. A team meeting was held to discuss the incident and to agree on the steps that should be taken if the incident re-occurred which included reviewing the safety management plan. Despite the team meeting the staff we spoke to were unaware of the actions to take in the event of the person self-harming. The safety management plan had been updated, however, staff had documented that they would support the person to "talk over concerns and support to build coping strategies". The details on the coping strategies and how the staff were to do this were not included in the plan. This meant that there were no clear guidelines or strategies for staff to follow to consistently manage incidents of self-harm.

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

The systems for the management of medicines were well managed. Some improvements with regard to the management of "as required medicines" (PRN) should be considered.

The provider's policy stated that when a PRN (such as pain relief or medicines used to reduce anxiety) were used, a care plan should be developed detailing how and when the medicines should be given. The staff were not following the policy. We saw that care plans were not in place. The service manager told us people knew when they needed these medicines. The lack of care of care plan would mean that staff may not be not clear when the PRN medicines were to be taken and there was little monitoring of symptoms which may require a review of the PRN medicine.

We recommend that the provider reviews the policy for the use of PRN medication and to ensure that it is implemented.

Individual medicine folders included a photograph of the person which assisted staff to identify the person. There was signed consent from those people that had agreed for the staff to administer their medicines. Medication Administration Records (MAR) were signed by staff when medicines were administered and indicated they had administered these medicines according to the prescribed directions. Where people were able to self-administer medicines their competency was assessed and regularly reviewed. One person told us they administered their medicines and their competency was regularly assessed. They said stock checks by the staff ensured medicines were taken as prescribed and that medicines were kept in a lockable storage provided in their bedroom.

People we spoke with said staff were available when they needed assistance or support. A member of staff said there was low reliance on agency staff and "staffing levels have always been good but an increase in staffing levels should be considered." They said this was because people with complex needs were accommodated. Another member of staff told us staffing levels had improved since the appointment of the service manager.

The staffing rotas in place showed there were higher staffing levels during the day. There were two staff and the service manager on duty until 3pm and lone working from 5pm. The staff on lone working slept on the premises but were available in the event of an emergency. This meant that staffing levels did not allow for people to be supported by the staff on a one to one basis if requested after 5pm. This may impact on the availability of staff to support people in the community in the evenings. The service manager said there was

flexibility of staffing levels and staff worked additional hours where necessary.

People were protected by the prevention and control of infection. A member of staff told us there were checks on the levels of cleanliness. They said people were responsible for cleaning their bedrooms. Staff carried out weekly health and safety check to ensure equipment and appliances were operating effectively. Bedroom checks ensured repairs were not needed, window restrictors were in place and electrical sockets were being used as recommended.

Requires Improvement

Our findings

Staff had not received all the necessary training to support them in their roles. The service supports people who have mental health issues. Apart from one, the staff we spoke with had not attended mental health training since their induction. The training matrix showed that one of the four staff employed had not attended any mental health awareness training. One staff had attended the training in 2009, another in 2010 and the third staff had attended this training in 2016.The head of services told us online training on mental health awareness was available to staff. They said training was to be monitored and improved. An audit of staff training had been completed by the manager in June 2017. This showed some training had expired and staff had not attended all training set as mandatory by the provider. The service manager told us of the arrangements to develop staff's skills in mental health awareness. However these plans had not yet been implemented.

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

There were arrangements in place for staff to have one to one meetings with their line manager. A member of staff told us since the appointment of the service manager one to one meetings had taken place with this manager. This member of staff also said their one to one meetings focussed on health and wellbeing, as well as personal development and their specific lead roles such as key working. Another member of staff told us one to one meetings with the service manager was to be two weekly. The service manager told us two weekly one to one meetings was a short-term measure to review support plans and goals with the keyworker.

People prepared their own meals. One person told us they managed their weekly budget well which included preparing meals such as curry's and ordering take away. They told us "I have my own money for treats such as crisps." A member of staff said people were provided with a weekly budget for food. They said they promoted healthy eating and part of the agreement for staying at the home was that energy drinks, alcohol, sweets, cakes or biscuits were not purchased from the weekly budget. They said since the appointment of the service manager there was fruit available to people. Another member of staff said the budget was to purchase "wholesome foods not chocolate." They told us staff supported people to prepare meals and review menu planners.

The catering procedure stated, "Service users complete a weekly menu planner supported by staff if required. This will detail what meals the service user if planning to eat for the week and ingredients needed.

This is an ideal opportunity to discuss menu ideas and options." We looked at some of the menu planner. The completed menu planners viewed lacked detail about the meals to be prepared. One person recorded tea and coffee on alternate days for breakfast and "olives" was recorded on one day for lunch. Another person had recorded "pizza" for one day and this person told us for the following day there was "leftover pizza." Although one person had refused to complete menu planners the staff said the receipts showed wholesome foods were purchased.

People were provided with individual lockable kitchen cupboards and space in the fridge for their food. Some people had a range of tinned and dried foods in their lockable cupboards and some foods were kept in the fridge. A member of staff said people were encouraged to label and date foods kept in the fridge.

People's care was not fully coordinated with external agencies. There was an agreed admissions procedure between the home and the local authority. This procedure was not followed. A social worker told us that there was an expectation that staff would develop care plans based on the needs that they had identified. A member of staff told us the procedures followed for admissions focused on the person's "needs and aspirations" and not on the social worker's care plan. Another member of staff told us before an admission the staff met with the person to assess their support needs and to identify goals and future plans. The plans we viewed showed that the agreed outcomes were not assessed and developed into support plans. This meant staff were not supporting people with all identified needs.

Most people had regular contact with a health and social care professionals. For example, Community Psychiatric Nurses (CPN), social workers and care coordinators. The staff also assisted people to access external support agencies to help them with achieving their goals and aspirations. The contact between people, the staff and social and healthcare professionals was recorded. These records were not clear and did not enable staff to find the outcome of the visits easily. The outcome of any visit was recorded alongside the daily care notes. We asked a staff member for the outcome of one visit that a person had attended, as a result of an incident. A member of staff said they had to "trawl through" the records. This meant staff needed to remember the author of the report and the date of the event before the recording could be found. The service manager told us a separate form to record contact with professional was to be developed.

People received support with their healthcare needs. The staff supported people to register with a GP and dentist. Where emergency care was needed staff supported people to access treatment.

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 living at the service had capacity to consent to care and treatment. People signed consent forms for having their photographs taken, sharing information and having medicines administered by staff. The staff told us and the training matrix confirmed staff had attended MCA training. There was lack of knowledge from the staff about their role with supporting people in making informed choice or the consequences of making some decisions.

The property had the appearance of a domestic dwelling which blended well with the local community. Accommodation was arranged over two floors with single lockable bedrooms and a bathroom on the first floor. The lounge, the kitchen and office were on the ground floor. Overall the property was well maintained except for the kitchen where the cabinets were in need of repair. A member of staff told us repairs had been

reported to the landlords who had acknowledged their requests. They said it was usual for the landlords to respond in a prompt manner.

Requires Improvement

Our findings

Some people did not want to give CQC inspectors feedback about their experiences of living at the service. These people were given unwise advice about the professionals that can access their records. We saw in care records where people had specifically denied the CQC inspector's access to their records or for the information contained in files to be used in their reports. Members of staff showed a lack of understanding on the role of the CQC and confidentiality procedures. Staff did not give people information on the CQC powers to access confidential records and that CQC do this to check that services were meeting required standards of care. The service manager told us that they would be explained the role of the CQC to people and staff.

Some aspects of people's rights were respected. Some routines such as administration of medicines were not person centred. People were not given the opportunity to make a decision on where to have their medicines administered. This meant medicines were administered in the office and in the presence of other staff, people and professional in the office.

People said their privacy was respected by the staff. One person told us they had a single lockable bedroom and keys to the front door were provided. A member of staff explained that to ensure people's privacy they knocked on bedroom doors and waited for an invitation to enter.

House meetings took place. At the house meeting dated 16 November 2017 cleaning tasks, visitors and activities were discussed. The service manager told us about house meetings were the forums for people to make suggestions and to openly discuss group living.

One person said the staff were caring because they had one to one time with their keyworker (staff assigned to work with specific people). They said during their one to one meetings goals to live independently were discussed. A member of staff said that keyworker time offered an opportunity to discuss issues without disruptions. Another member of staff said having one to one keyworking time with people ensured people felt that staff were caring. They also said we "treat people as an individual."

Another person told us they liked living at the home because there was a "chilled out" atmosphere and the "staff were friendly". A member of staff said "I spend time together with people. We [staff] try to support people in the community which provide an opportunity to talk." Staff also said there was a stable and mixed range of staff available for people to discuss their interests and to seek advice.

We saw observed people approaching staff for support and assistance. The staff response to people was respectful and sensitive to their requests. When people became distressed we observed staff using a sensitive approach to ensure the person was reassured. We observed staff give people guidance on the routines of the homes and gained consent before delivering care.

Requires Improvement

Our findings

Support plans were not developed on how staff were to meet people's complex needs. Action plans which identify signs of deteriorating mental health and the assistance needed from staff were not in place. For example, psychotic behaviours, addiction and self-harm. One person told us "I probably do have a support plan."

Procedures in place did not tell staff to develop holistic support plans based on peoples identified needs. The Integrated Support and Planning procedure state that "Each person using our service will have at least one agreed goal or specific issue that service staff are working with the service user to achieve." While the support plans in place detailed the person's goals and aspirations, support plans were not developed on all needs identified within the social worker's care plan. A member of staff said support plans were devised by the service manager or another member of staff with lead roles in this area. Another member of staff said they followed the Integrated Safety and Support planning procedure which focussed on the goals the person had identified for development. They said where the person was "no longer happy to work with the agreed need" senior managers were alerted about the changes. For example, supporting people that have disturbed eating patterns. This meant people were not helped to understand their care and treatment choices.

Support plans for one person were not based on all the listed actions the social worker had identified within the care plan. For example, support with budgeting, arranging GP appointments and to share concerns with professionals. The social worker's care plan included guidance to staff on the administration of medicines during periods of drug and alcohol misuse. We saw recorded an instance of alcohol misuse which confirmed that guidance relating to the administration of medicines in the social worker's care plan was not followed. This meant staff were not supporting people in a way that ensured the identified needs were consistently met by the staff.

The Integrated Support Planning procedure was not fully followed by the staff as support plans did not identify who does what by when. A "Recovery Star" was used by the staff to help the person assess their position in relation to eight specific key principles which included "Self Care," "Living Skills" "Social Network" and "Addiction". At the three monthly reviews the person was helped to re-asses the progress made with the identified goals and targets. Although staff assisted a person to join support groups to maintain abstinence, the support plan did not include the assistance needed from the staff to access daily treatment for addiction. For example, administration of substitute medicines.

On the first day of the inspection we were provided with paper copies of the support plans and during discussions with the staff we established that online support plans were not kept. On the second day we were told that an online system was used to record and update risk assessments. On the third day of the inspection we were told an online system was used for support plans. A member of staff told us online support plans "should mirror the paper copies." Records had to be reviewed on each day to ensure our findings were accurate.

People's daily records included details of direct care provided, how people spent their day and outcomes of appointments. The service manager told us the handover of information was to be reviewed and was to be streamlined.

Staff had not worked with people to develop support plans on how to access community facilities, take part in activities and develop their independent living skills. One person told us how they had voluntary employment. Another person told us they spent their day playing computer games or visiting family and friends. Staff told us two people had once weekly voluntary employment and one person attended college daily. They said there was an expectation that people participate in the independent living skills. For example, laundry, meal preparation and keeping their rooms tidy. We noted that two people were not participating in any meaningful activities and the people on voluntary employment opportunities accessed them weekly. Support plans were not in place on how people were to access community facilities, participate in meaningful activities and on the support needed with independent living skills. The minutes of house meeting held on 16 November 2017 detailed that in-house activities were to be reinstated. For example, theme night, films and board games.

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

One person told us they would approach staff with complaints. A member of staff told us they had attended complaints training. This member of staff stated they responded to all concerns and they attempted to resolve concerns as they occurred.

There were no complaints received at the home since the last inspection. The service manager told us people were to have training in complaints. This was for "people to understand their feedback is valued" and to encourage them to raised concerns.

Requires Improvement

Our findings

A registered manager was not in post. An interim manager was appointed on 18 December 2017 but an application to register with CQC as manager had not taken place. An additional "service manager", who had the day to day responsibility of the service, had been appointed in December 2017 and was line managed by the interim manager.

A member of staff told us there had been five changes of managers in 12 months. Another member of staff said that steps were being taken by senior managers to ensure a suitable [registered] manager was appointed. This member of staff said that there had been a number of managers appointed which they found positive and felt the experience had "shaken-up" the staff team.

The aim of the service was to support people to move into more independent living. Although some procedures in place were to help people with independent living skills staff were not knowledgeable about the scope of regulations. Staff lacked insight into fundamental standards, how to introduce changes of legislation and partnership working. For example, enabling people and working with regulators.

Systems to assess and monitor the quality of service delivery were not robust. The service manager told us it was the responsibility of the [registered] manager to assess the quality of care delivered through a range audits. They said since their appointment there had been weekly internal medicine audits and financial audits were to happen the following week.

We discussed with the head of services how the provider assessed and monitored the quality of the service delivered to people. We raised concerns about the lack of leadership due to the changes of managers and about our findings in relation to safeguarding, risk management, medicines, training and person centred planning. The head of services told us the quality of the service was assessed by an internal quality assurance management team and these visits were annual and announced. They said it was the responsibility of the [registered] manager to develop an action plan of improvements from shortfalls identified. The head of service acknowledged that there was a lack of progress with implementing improvements due to changes in managers.

We requested copies of all audits of the service. These were provided and were dated 1 June 2017. The outcome of the audit was an overall "fail" based on the shortfalls identified. An email to the interim manager dated 2 June 2017 from the quality assurance team stated "Priorities for action are the meds system, the residents monies system and sorting out training records I have listed actions needed with deadlines and

support options if needed. Support planning will take a bit of thinking through." There was no evidence that these actions had been implemented to improve the service.
Regarding risk assessments it was documented in the audit that "the issue is there is either no or limited safety management plans to go with the risk assessment which is being used as the safety plans erroneously –support plans are in place but narrative is limited." This shortfall had not been added to the action plan. The head of services said the quality of the support plans were not assessed closely during the visits.

The training of staff was assessed in the audit and it was documented that there was "no logical process to ensure skills and training where kept up to date before they expired." The action plan was for the manager at the time to "ensure all refresher training done by staff including outstanding MCA training identified in audit". This action was in progress. However, it was not identified that three staff had not had refresher mental health training.
Medicine systems were audited and shortfalls were identified. However, protocols for medicines prescribed to the taken as required were not identified as missing. Also it was not identified that people were not able to have their medicines administered in their preferred manner.

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

The service manager told us that senior managers were "invested and committed to make improvements." They said an improvement plan was in place. The copy of the improvement plan provided listed the actions needed to improve the quality of service delivery. For example, reviewing of support plan and audits of systems.

Health and safety audits were completed provider level and were analysed through online reporting by staff. The Health and Safety Audit which took place in June 2017. The audit had identified shortfalls and the interim manager had developed an action plan on how outcomes were to be met. The action plan in place detailed the timescale and the designated staff responsible. This action plan had been actioned and the interim manager had signed the audit action plan as complete in July 2017.

The values of the organisation were on display in the office. A member of staff said the team was "strong" and that "we all have different strengths. We are a small team and things get done." Another member of staff said the team "worked well together" and there was a "common purpose" between staff. They said "the team held it together during periods when there was a vacancy for a [registered] manager."

Arrangements were in place for staff to receive feedback, which enabled them to take appropriate action. The copies of the two most recent meetings listed the areas discussed which included management updates, training and policy changes. During staff meetings there were discussions on learning from events.

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 9 HSCA RA Regulations 2014 Person-centred care Support plans were not devised on all areas of need. Where people refused to develop a goal or needs were identified the staff did not help people understand their care and treatment needs. People were not helped to develop meaningful activities which helped them improve their personal development.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were identified but action plans were not devised on supporting people to take risks safely or to minimise the risk to the person and others. .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

improper treatment

The staff had not followed safeguarding procedure. Staff had failed to report allegations of abuse when asked not to reported abuse. Their responsibility to report abuse was not explained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality of service delivery was not monitored or fully assessed. Systems were not robust and all areas of service delivery were not assessed. Where shortfalls were identified there was little monitoring on progress made with meeting the outcomes identified for improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken steps to ensure the staff were able to develop their skills and the knowledge needed to perform roles. The training records were not monitored to ensure staff had attended appropriate training that met the needs of people with complex needs.