Aspire Healthcare Limited

Park 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**

Overall summary

We visited the service on the 13 & 14 October 2015. Day one of this inspection was unannounced. We also spoke with staff on the phone on the 3 November 2015.

This service was last fully inspected in July 2013 and action was needed to improve the environment. When we last visited in October 2013 the service had improved and was compliant with the legal requirements in force at the time.

Park House is a seven bed care home that provides personal care and support to people with mental health issues and learning disabilities, and support to moderate or manage alcohol or substance misuse. There were six people living there at the time of our inspection. The service had a registered manager who had been in post since 2010. 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 did not always keep people safe from the risk of harm or abuse. The service failed to effectively manage

Summary of findings

the behavioural needs of a person using the service which left other people at risk. Plans to reduce this risk had not been acted upon and people continued to be exposed to avoidable harm over a period of time.

Incidents which occurred in the home had not been reviewed and acted upon to reduce the likelihood of these occurring again. Access to, and the security of, the service had not been reconsidered following an incident, leaving a risk of a repeat event.

People told us they liked the staff team and they were always available to meet their needs.

Staff were not receiving regular supervisions and appraisals of their performance. Staff told us they had requested training to meet people's needs around behaviour support, alcohol and drug use and that this had not been provided. Staff training was not always up to date and steps had not been taken to address this. Staff did not have the skills and knowledge to meet people's diverse needs and had not received the appropriate training to support people.

The service did not adequately involve the people in the development of the service and this was seen to be limited in scope.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The provider had not taken steps until recently to identify people who may need review under the DoLS.

People told us they felt the staff team were caring and supported them. We observed positive interactions between people and staff. However this had not been the case recently when behavioural issues had a negative impact on the home. People and staff felt the service and the registered manager had not managed this effectively.

People's care plans and records did not clearly identify what goals they had to support people's development. Reviews were limited, with some goals ongoing over extended periods of time with no change in approach and no discernible development or improvement in the level of people's needs.

Concerns from people and staff about people's behaviour, and the impact this had on the service, were not always acted upon effectively. We saw that there had been a number of behavioural incidents and staff told us they raised concerns, but that no action was taken by the registered manager to improve the situation.

Complaints had not been acted upon correctly. Records did not show that the registered manager took action to resolve the issues raised by people using the service.

The service had failed to notify the Care Quality Commission of significant incidents such as police attendance at the service or when staff raised safeguarding alerts with the local authority.

The registered manager held multiple roles within the organisation and much of the day to day responsibility was delegated to a team leader. Quality system checks and audits in the home were not thorough and there was a lack of critical review of the service by the registered manager and team leader.

Summary of findings

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 inadequate. Staff lacked the skills, knowledge and guidance to keep people safe and prevent harm from occurring. Not all staff were confident they could raise any concerns or issues in the service and that they would be addressed.

Staffing was organised to ensure people received support to meet their care needs.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work with vulnerable people.

People's medicines were managed well; if people managed their own medicines the risks had been assessed.

Is the service effective?

Requires improvement

The service was not always effective. Supervision and appraisal processes were not in place for all staff to receive feedback on their performance and identify further training needs. Staff training was not up to date.

People could make choices about their food and drink and alternatives were offered if requested.

Arrangements were not always in place to meet people's health needs.

Staff demonstrated they had an awareness and knowledge of the Mental Capacity Act 2005, which meant they could support people to make choices and decisions where they did not have capacity. Staff were less familiar with the Deprivation of Liberty Safeguards and had not identified people whose capacity should have been assessed.

Is the service caring?

Requires improvement

The service was not always caring. The staff mostly had a good relationship with people using the service, but this had not been consistent over the last six months.

Staff did not always have the skills and knowledge to respond to the diversity of people's backgrounds.

Is the service responsive?

Requires improvement

The service was not always responsive. Some care plans did not contain the level of detail needed to support people's needs.

Issues and concerns about people's challenging behaviour had not been responded to, leaving others at ongoing risk. People and staff told us they had raised concerns but were unclear if and how they were resolved by the registered manager.

Summary of findings

Complaints had not been managed effectively and records had not been kept to show the outcome.

Is the service well-led?

Inadequate

The service was inadequate. Staff and people told us they had raised concerns about people's behaviour and the impact this had on the service and that action had not been taken. The registered manager held multiple roles in the organisation and was not always present in the service.

Incidents which should have been reported to the Care Quality Commission had not been sent as required. There was limited audit and review of incidents in the service and incident records logs were sometimes inaccurate.

Partnership working with external professionals had not always been effective in managing people's behaviour.

Park House

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 October and day one was unannounced. We spoke to staff via telephone on 3 November 2015.

The inspection team was made up of an adult social care inspector and a specialist advisor. A specialist advisor is a professional with experience of this type of service provision.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted commissioners of the service and the local authority safeguarding team for any feedback. We reviewed the information we had received from a recent whistle blower (staff member) in the service.

During the inspection we spoke with nine staff including the registered manager and team leader, as well as three people who used the service.

Four people's care records were reviewed as were the staff training records. Other records reviewed included: safeguarding adult's records and accidents/ incidents. We also reviewed complaints records, six staff recruitment/ induction/supervision and training files, and staff meeting minutes. The registered manager's action planning process was discussed with them as was learning from accident/ incident records.

The internal and external communal areas were viewed as were the kitchen, dining area, bathrooms and, when invited, some people's bedrooms.

Inadequate

Is the service safe?

Our findings

People told us they currently felt safe, but there had been occasions where they had not felt safe previously. People we spoke with all told us the same thing, that some people's behaviour had not been managed well by the staff. Some staff told us they had previously felt unsafe working with one particular person, and that they did not know how to manage the challenges they posed the staff team. Staff told us that people often stayed in their rooms when this person had been present in the service. This meant that the service had not responded to people and staffs concerns about challenging behaviour or taken action to reduce the likelihood of this occurring again.

Staff were aware of safeguarding adult's procedures. Safeguarding alerts had been raised with the local authority, but effective action to keep people safe had not been taken by the service. One person had been identified as at risk of verbal threats. A risk assessment and care plan was put in place by staff to manage this issue. However, from checking records and speaking to staff we could not find evidence this care plan had been followed and the person remained at risk of further verbal abuse. Records showed that over the following months there were at least three further incidents where the person had been subject to further abuse. Some staff we spoke with told us this was probably under recorded as it was so frequent.

This was a breach of Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and team leader had a routine of checks within the home for health, safety and the environment. We reviewed these and they were happening regularly, but it was unclear what was being checked each time as the records kept were generalised. We discussed this with the registered manager and team leader who agreed to make them clearer and more detailed to improve consistency in approach.

The smoking room extractor fan was not working and staff were not aware of this, we drew this to their attention. The smell of cigarette smoke was noticeable throughout the building in communal areas. The smoking room was heavily stained and in need of re-decoration. There was also an ongoing leak from the first floor communal shower and need for repair to the back panel surround of a toilet.

In one bedroom the hand basin water temperatures were above the recommended range for safety. This had been identified in earlier audits but remained unchanged as the provider or registered manager had failed to take any action to rectify the issues.

There had been an incident earlier in the year when an unknown person had entered the premises. They were challenged by staff and they left. This incident was not reported to the police by staff or management. A neighbour notified the police. The police took a statement from a person living there after they identified an item may have been stolen. The building's main door remained unlocked through the day and people did not routinely have their own keys to access the property. No action was taken by the provider to review access security for the service after this incident so people remained at risk.

This was a breach of Regulations 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had evacuation plans in place for each person and had regular fire alarm and evacuation tests. The service did not have a clear contingency plan in place for possible evacuation, in the case of fire. The registered manager agreed to put a 'grab bag' with emergency provisions and a clear contingency plan in place.

The Care Quality Commission (CQC) was contacted in September 2015 by a whistle blower staff member who raised concerns about the risk posed to people at Park House and the staff team. They also had concerns that the staff team had tried to raise concerns with the registered manager but no clear action had been taken. We subsequently raised a safeguarding alert with the local authority. We discussed this with the registered manager; the provider had a whistleblowing procedure where staff could contact the nominated individual at the provider's office, the local authority, or the CQC. The registered manager felt that they had listened to staff's concerns about this risk and taken actions to resolve the issues. However from talking to staff and people and from records we reviewed, we judged that the risks to people had remained an ongoing issue until very recently.

We reviewed accident and incident records in the service. Most of the incidents recorded were on ABC charts (Antecedents, behaviour and consequence) which were used to analyse the incidents, of which almost all related to

incidents of challenging behaviour. This was mostly verbal abuse or threats made against staff, but included harassment and threats made against people using the service. We reviewed one month of these records which were at the service, (July 2015). We found there were 19 such incidents recorded in that month. When we looked on the providers central data base (SharePoint) we found that only 13 of these had been logged against the July record. We found many incidents reported by staff had not been formally logged onto the service's central data base. We asked the registered manager and team leader about this discrepancy and they advised they had intermittent access to their IT system, but could not explain the discrepancy in July 2015. We asked the registered manager what learning or actions had been taken as a result of these incidents. They advised the ABC charts had been shared with external professionals, who supported them with the person in question, to seek their advice and input. We did not see that any changes had been effected to protect people or staff from further incidents.

This was a breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was enough staff available to meet the needs of people at the service throughout the day and night. People told us there was always someone there to support them when they needed help. Staff told us they worked alone at night but that there were senior staff on call who could be contacted if they needed support.

We reviewed staff recruitment files; these showed that all staff went through an application and interview process which included references and police checks, to ensure only suitable applicants were employed.

We observed a medicines round and reviewed people's medicines records. We saw that one person was managing their own medication with staff support. This was risk assessed and managed well between staff and the person. We saw that people were supported to take their medicines in a safe and dignified manner. Records showed that a recent audit had found a medication error. The service reported this and dealt with the matter through disciplinary measures and re-training of the staff involved. Staff told us they had attended training on the safe handling of medicines. Records were kept of the temperature of the fridge used for medicines storage to ensure safe storage of medicines.

Staff undertook cleaning duties in the home as well as supporting people to maintain their bedrooms. We could see that suitable gloves and cleaning equipment were available and the home was generally clean. Staff told us how they would wash their hands before providing care, and soap and towels were available. We found that one bathroom had a bin with a lid which needed the person to touch it to open, which posed a risk of contamination. There was no sanitary bin available for females. We discussed this with the registered manager who agreed to take immediate action.

Requires improvement

Is the service effective?

Our findings

People told us the staff were good at their jobs and knew them well. One person told us, "The carers are nice, they know when I need some space and help me with the doctors and stuff." We saw positive interactions between staff and people, where they were relaxed and comfortable in each other's company.

We saw the service's mandatory training matrix, this was sent to us after the inspection. On this we could see that all staff were overdue to attend refresher training on medication, COSHH (Control of substances hazardous to health) and Equality and Diversity. Some staff were also overdue to attend training on health and safety and food safety. Staff training files did not contain an accurate picture of what training staff had attended as some certificates had not been filed or records kept. The registered manager had been unaware of the training deficits for staff prior to the inspection.

Staff were supported to complete their National Vocational Qualifications, (NVQ's) in care, now called the Care Certificate. The team leader was being supported to complete the NVQ (Now called Qualifications and Credit Framework) management modules. However staff training records did not show that all staff had the training they needed to support people well. Some people had alcohol dependency issues, but staff did not have specific training on appropriate support techniques. Staff told us they did not have the training they needed to support people with behaviour which challenged. One staff member told us, "I have asked for challenging behaviour training, and it's been promised, but it's never happened." We could see from staff meeting minutes and supervision files that this training had been identified as being required by staff on several occasions since March 2015. We asked the registered manager about this and they advised they had looked at ways of providing bespoke behaviour support training during this period, but to date nothing had been arranged.

We looked at staff supervision and appraisal records. The provider's policy and the registered manager stated that staff should be supervised every two months and have an annual appraisal. From records we saw this was not happening in line with the policy. One staff member only had one recorded supervision each year; another had only one supervision record for the previous four years. Annual appraisals were happening more frequently, but not consistently across all the staff team, with one having only one recorded appraisal in ten years. Staff we spoke with told us they got informal supervision regularly from the team leader, but confirmed that formal recorded supervisions did not happen as frequently as stated in the service's policy.

Supervision records also highlighted training needs; one identified the need for challenging behaviour training, but this had not been actioned. One section of the supervision form afforded staff an opportunity to get people's feedback as part of the process. These sections were either blank or stated people were 'not available'. Other sections of the standard supervision form were left blank so it was unclear of the quality of supervision on offer. When we asked the team leader about supervision they agreed to review the form and told us they had a schedule to carry out appraisals by the end of October 2015 and start regular supervisions.

These were breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had regular staff meetings and 'house forums' where they met with people to discuss the service. People we spoke with told us the house forum was useful and they could influence the menus. From reviewing the minutes of these meetings we could see they were not well attended. The team leader told us they were looking at ways to gain more informal input and feedback from people using the service.

The Care Quality Commission monitors the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There was no one at Park House subject to the safeguards at the time of inspection. The registered manager told us they had attended update training recently and had identified a person who met the criteria and they were making a referral for assessment. Staff we spoke with were not aware of the change in guidance following the Supreme Court ruling of 2014. This meant staff were not aware of the new criteria regarding when to make an application to deprive someone of their liberty. This meant people may have been subject to a deprivation of their liberty without the legal safeguards being in place.

Staff had attended training on the MCA, and we saw staff seeking people's consent before carrying out tasks or when

Requires improvement

Is the service effective?

supporting them with medicines. We saw that people had signed their care plans to give their consent. One client had their finances managed by a local authority. We saw from records that staff worked with the authority and the person to help manage their finances. This prevented them from placing themselves at financial risk.

People told us they mostly liked the food, that they could influence the menus and that alternatives would be provided if requested. Staff told us how they used the staff forum and a notice board in the dining area to seek people's input into the menus. Fresh fruit and vegetables were available. Snacks and drinks were available if people requested them. One person told us they didn't like one meat supplier, it was changed and was now much improved.

People were supported by staff to access their doctor, dentist, optician and chiropodist as required. Some of the people using the service had a history of poor health and self-neglect. People at times had declined advice and support with regard to their healthcare, although it was not always clear in records how people were supported to maintain their individual wellbeing. For example people had refused monitoring of long term health conditions by specialist healthcare professionals. It was unclear how these conditions were being monitored by staff to ensure people's wellbeing was maintained.

The service was over three floors with a staircase as access to all floors. The main communal lounge on the ground floor was also the smoking room, with the dining room as the only other communal area, also on the ground floor. Not all people who lived at Park House smoked and staff recognised this was an issue for the non-smokers. We discussed this with the registered manager who told us they were reviewing smoking arrangements with the people living there.

Requires improvement

Is the service caring?

Our findings

People who used the service told us they liked the homely atmosphere. One person told us, "I know they will look after me when I need help." This had not been consistent over time though as people also told us that relations had been poor with a person who had recently left the service. People told us that they had witnessed verbal abuse from this person directed against staff and some people who lived there. People told us that the atmosphere was much improved now.

Staff we spoke with talked in a positive way about people using the service and knew their histories well. We saw caring and sensitive interactions between people and staff and there was a relaxed, informal atmosphere.

Peoples care plans had areas for staff to consider people's cultural and diversity needs. However, the recording in these areas was limited, for example "Likes British food." It was unclear what level of involvement people had in reviewing these parts of their care planning. Staff told us they did not have any training on equality or diversity. One person we talked with about their care plan was not able to tell us what their care plan was for. They told us it was about the medicines and their doctors' appointments, but appeared to have no other understanding of what the care plan was for. Staff we spoke with told us that people generally did not want to be involved in their care planning, or reviews of their care. It was unclear how staff had established that people did not want this involvement as there was no evidence of them being given the opportunity to be involved in care plans. We did not see any entries in care plans that indicated that they had been discussed and that people had refused to be involved.

The service had a house forum and the team leader told us how they encouraged people to be more involved in making choices about how the service was developed. Apart from the notice in the dining area about menu choices there was no other information displayed about other plans in the service. Staff told us these forums were poorly attended and they were looking at ways to seek more informal feedback and discuss changes to the service.

The standard staff supervision recording sheet had a section to give the supervisee feedback from people using the service. From the records we saw these had either not been used, or recorded that no one was available to seek feedback from.

The staff office was on the top floor, staff told us this was not used often as it was so removed from where people were on the ground floor and the services Wi-Fi did not work there. This meant people's files and records were stored in a locked cupboard and much of the activity of the service took place in the smoke free dining area. Staff told us that if they needed to speak with someone about a private or confidential matter they would use the office.

Some people had a history of poor personal care and self-neglect for themselves and their bedrooms. Staff told us how they encouraged people to bathe, change clothes and dress appropriately to increase their self-esteem. We saw that staff reinforced this through positive comments after one person showered and shaved. We saw this made this person's demeanour change for the better immediately. One person was seen to be moving about the house partially clothed and staff intervened and encouraged them to dress appropriately.

We recommend the registered manager develops methods to gain people's feedback on the service and increase their involvement in the service.

Requires improvement

Is the service responsive?

Our findings

People told us the staff were able to respond to their needs quickly. They also told us that previously there had been one person, who had recently left the service, who had disrupted this. They told us that staff had struggled to meet the needs of this person and that they distracted staff from the normal routines of the service.

Care plans and records we reviewed showed that people had plans that were about general support throughout the day and night to maintain their wellbeing. People had an initial assessment of their needs, but records did not show much change in their needs recorded over time and there were limited goals or objectives. Of the four care plans we reviewed there had been no changes to any of them in the previous six months. There was little evidence of people being involved in their care plan reviews. People we spoke with had limited knowledge of what was in their care plans, though they had signed their care plans to give consent.

There were specific care plans around managing alcohol and finances for some people. These were more detailed and showed clearly where the person had been consulted in reviews of the effectiveness of these plans. When we spoke to one person about their plan for managing their alcohol consumption they told us they did not always follow the plan and had relapsed. In reviews of this person's plan there was some notes of the period of relapse, but no overall evaluation of the plan's effectiveness or any changes to the support on offer. When we discussed this with the team leader they agreed that reviews had been limited and would review this with keyworkers.

People and staff told us there were no regular activities planned in the service. People were mostly supported as individuals to attend appointments, go shopping or to the pub on an ad hoc basis. People told us the staff supported them with these kinds of activities regularly and they enjoyed the time spent with staff. There had also been a recent trip to Leeds. Both staff and people told us that they thought there should be more activities developed in the service. Two people we spoke with said they were often bored and spent a lot of time in their rooms watching television as there was nothing else to do.

One person had a care plan to encourage them to socialise more and spend more time outside their bedroom. Reviewing back over six months we saw that this had a limited impact and the person still spent most of their time alone in their room. This plan was reviewed monthly, but no changes had been made to the plan.

We looked at complaint records and saw that one person had complained about an issue in May 2015; and the service's failure to manage this issue effectively. The complainant felt this was having a negative impact on their and another person's wellbeing and the service generally. In this complaint record the person states they are 'fobbed off when (They) complains'. We looked at the records and there was no information to say how the service responded to this complaint, or if anything had changed as a result. The outcome section on the form stated 'Reported to safeguarding'. There was no record of what feedback the complainant received at the end or the final outcome. We asked the registered manager about this and they could not recall what, if any feedback they had given to the complainant. In a letter from the provider dated 12/10/15 following a safeguarding adults meeting, they stated the complaint had been withdrawn. But this was not recorded anywhere in the complaint records.

This was a breach of Regulations 12 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us they liked the registered manager, team leader and staff team. They thought that they usually provided a good service but that this had not been the case recently as an issue of conflict between people in the service had not been resolved by the management team of the service. People told us this situation had a detrimental effect on the service.

Some staff we spoke with felt the registered manager and team leader were approachable and supportive. Other staff we spoke with felt the registered manager and team leader hadn't responded to concerns they raised about issues within the group of people living in the home. Some staff told us the registered manager ignored concerns they raised about people's behaviour and safety. Staff told us they had asked for challenging behaviour training and this hadn't been followed up. One staff member did not feel able to speak to us, they told us "I need this job and can't afford to complain."

The registered manager was also an 'Area Manager' for the provider, and was registered manager for another location. Most of the day to day management was the responsibility of the Team Leader at Park House with the registered manager available via phone. The Team Leader was presently studying the NVQ (Now Qualifications and Credit Framework, QCF) level 5 in Management. The Team Leader's supervision file did not contain evidence of regular formal supervision and appraisal by the registered manager. We asked the registered manager about the supervision and appraisal they both received. They told us they met with the nominated individual regularly, but that records of these discussions were not kept. We were unable to clarify how the leadership staff at Park House were supervised and appraised on their performance. The impact of this meant that issues were not always identified and consistently addressed by the team leader and registered manager promptly. For example, staff we spoke with told us they had raised concerns with the team leader and registered manager about the issues with challenging behaviour and that they needed training to meet their needs. Supervision records and staff meeting records confirmed this had been requested, but to date this had not been sourced by the registered manager. When we asked the registered manager about this they advised they had spoken with external professionals who offered to develop this bespoke training. However, there was no further evidence to support this. This had not led to any clear date for training to begin.

Following a whistle blower contacting the CQC in September 2015, a safeguarding alert was raised and the safeguarding team asked the provider to undertake an investigation into the concerns raised. This investigation is summarised in a letter to the safeguarding team from the provider of the 12/10/15. The registered manager informed us they had carried out the majority of the investigation, despite one of the issues raised being that staff had informed them (the registered manager) of concerns, and they had not acted upon them. This was a potential conflict of interest. We asked the registered manager about this, but they told us they had not considered this potential conflict of interest.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had sent the CQC statutory notifications, these are incidents which providers are required to inform us of. However, we found records which showed that the police had visited the service after the alleged theft, and two occasions where the service raised safeguarding alerts with the local authority. No notifications had been sent to the CQC regarding these incidents. We asked the registered manager about this and they were unclear if notifications had been submitted, and were unable to show us any supporting records. They told us they had IT problems which may have accounted for them not being submitted correctly.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4).

We asked the registered manager about the large number of ABC records that had been completed about the behaviour of one person. We asked them what learning had taken place after these incidents to reflect upon and prevent further occurrence. They advised that these were shared with external professionals who would advise the staff team on the further development of the care plan. We asked them what changes had been made as a result of sharing these ABC records. They advised this was being used to help develop future training for staff which one of the professionals had offered to provide. However, staff we

Inadequate

Is the service well-led?

spoke with were unaware of any changes to the way they managed this person's behaviour. Some staff told us that other staff used different methods to manage their behaviour which they did feel were consistent. Staff told us they had raised these concerns with the registered manager who had not responded. Records we reviewed did not show any analysis or monitoring of these incidents to reduce the risk of further occurrence. This meant there was a likelihood of further incidents which could have been avoided.

The registered manager, also being the area manager, did not have any additional audits carried out at Park House from anyone else from the provider organisation. Reviews and audits of the home, care planning and medicines management were therefore carried out by the registered manager or the team leader. There was limited evidence of questioning practice in these reviews which meant the service remained largely static and issues we identified in this inspection were not identified in their internal reviews.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they met with fellow managers and shared experiences and good practice across the provider organisation. They were unable to show us any action or development plan they had for continuing to improve the service at Park House.

During the inspection we requested training records for staff from the registered manager. These records were not available and the manager told us this was because there were IT issues. We requested that this information was provided after the inspection. When the registered manager provided this information, they stated that they had been unaware of overdue training until checking the documents prior to sending to us. This indicated that the registered manager was unaware of the overdue staff training until the inspection. It was unclear how the registered manager had ensured that staff were appropriately trained to meet people's needs and how this was being monitored by them. We also found this to be the case with staff supervision and appraisal. The manager was not aware of these failings until the inspector raised the issues during the inspection.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.** **The registered person failed to provide safe care and treatment by not doing all that is reasonably practicable to mitigate any risks and by failing to ensure that person providing care or treatment had the qualifications, competence, skills and experience to do so safely.** **Regulation 12 (2) (b) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.** **The registered person had not taken steps to protect people's personal property. Or to have regular health and safety and risk assessments of the premises and act upon them without delay.** **Regulation 15 (1) (b) (e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Complaints.**

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not taken steps to fully investigate and take necessary action in response to a failure identified in a complaint.

Regulation 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The registered person had not assessed, monitored or improved the quality of the services provided. They failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users who may be at risk.

Regulation 17 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The registered person failed to ensure that person(s) employed by the service provider received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

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 registered person had not established system and processes that operated effectively to prevent abuse of service users. And failed to establish and operate to investigate, immediately upon becoming aware of, any allegations or evidence of such abuse. Regulation 13 (2) (3)