Cascade Care Limited

Cascade 4 - Newick Road

Inspection report

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Date of inspection visit: 3 December 2014
Date of publication: 20/03/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 3 December 2014 and was unannounced. We found that the provider had not taken sufficient action to address the shortfalls identified at the last inspection which took place on 18 August 2014. This was in areas around the care and welfare of people, nutrition, standards of cleanliness and hygiene and quality monitoring of the service.

Cascade 4 Newick Road is a care home providing 24 hour care, support and accommodation for up to five people with mental health needs. The provider has a number of other care homes in the local area.

There was a registered manager at the service who had been in post for about one year. 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 and associated Regulations about how the service is run.

At this inspection we found serious concerns about the safety and care of people who used the service. There were high levels of risk to the safety and welfare of people, including incidents of physical and verbal

Summary of findings

aggression affecting the safety and wellbeing of people who used the service. Issues identified at the last inspection had not been addressed to ensure that the premises were drug and alcohol free or to ensure people banned from the premises did not visit. This had a negative impact on people's mental health and their behaviour. Risks to individuals were not proactively managed to ensure steps were taken to minimise any risks and protect them from harm.

At our last inspection we found that standards of cleanliness and hygiene were inadequate. Although some improvements had been made we found that the kitchen was still in an unacceptable state and the lack of cleanliness and hygiene posed an infection control risk.

Staff had not received training in relation to meeting the needs of people with a mental health diagnosis. Therefore they were not equipped with the knowledge and skills they needed to meet people's needs effectively. Staff told us that they did not feel adequately equipped to support people effectively as they had not received training specific to people with mental health needs.

There had been no consideration given to Deprivation of Liberty Safeguards or consent issues in relation to the restrictions imposed on people who used the service. For example, care plans indicated times when people were restricted from leaving the premises and from using the kitchen, however, the appropriate procedures had not been followed to ensure this was lawful and in people's best interests.

At our last inspection we found that there was limited choice of foods available for people to eat. We found that some steps had been taken to address this, however, there was still inadequate quantities of food to enable people to prepare meals and snacks for themselves.

There was a lack of joint working with health and social care professionals to ensure that the service was responsive to people's needs. Care plans had been revised and updated using the 'Recovery Star' tool, however they still were not sufficiently personalised to outline individual needs and how to meet them. There was a lack of evidence that individuals made progress in line with their plans; how people were being supported to address their mental health needs and of their engagement in social, leisure and daily activities.

The provider could not demonstrate that a robust complaints system was in place to listen to and learn from people's concerns.

Whilst people expressed their views in their one to one meetings with senior staff, staff did not always act in a way that demonstrated that people's views were listened to, understood and acted upon. There was insufficient evidence to demonstrate how the service provided a supportive environment for people in a way that helped maximise their opportunities and potential towards achieving their individual goals and aspirations.

People who used the service had mixed views about how staff interacted with people. Some said staff were kind and caring and treated them with respect, whilst others expressed concern about how staff treated them.

The provider did not have effective systems in place to monitor and review incidents, concerns and complaints. This meant that there was inadequate learning from incidents to support improvements to the service. Quality monitoring systems were ineffective and did not protect people from inappropriate and unsafe care. The provider had failed to identify and address the shortfalls we found during this inspection and had failed to take adequate action to ensure that shortfalls identified at the previous inspection were addressed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report. As we have identified continued breaches of regulation we have taken enforcement action against the provider.

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 not safe. We found serious concerns affecting the welfare and safety of people who used the service. Identified risks were not managed effectively and therefore did not protect people from harm.

The premises were not clean and hygienic which posed an infection control risk.

Staffing levels were adequate and recruitment checks were completed to ensure that staff were suitable to work with people using the service.

Is the service effective?

Inadequate

The service was not effective. Staff lacked essential mental health awareness training and lacked the knowledge and skills they needed to perform their roles and responsibilities.

The provider had not taken steps to ensure that people were only deprived of their liberty when this was in their best interests as the law requires under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We saw limited evidence that people were involved in decision making and asked for their consent in relation to their care and support.

There was insufficient food available to enable people to prepare snacks and meals for themselves.

People were supported to attend routine healthcare appointments and appointments arranged with mental health professionals.

Is the service caring?

Inadequate

The service was not caring. Whilst people expressed their views in their one to one meetings, staff did not always act in a way to demonstrate that people's views were listened to, understood and acted upon.

There was insufficient evidence to demonstrate how the service provided a supportive environment for people that helped maximise their opportunities and potential in relation to achieving their individual goals and aspirations.

People who used the service had mixed views about how staff interacted with them. Some said staff were kind and caring and treated them with respect, whilst others expressed concern about how staff treated them.

Is the service responsive?

Inadequate

The service was not responsive. There was a lack of joint working with health and social care professionals to ensure that the service was responsive to people's needs.

Care plans had been revised and updated, however, they still were not sufficiently personalised to inform staff about people's individual needs and how to meet them. There was a lack of evidence that individuals made progress in line with their plans; how people were being supported to address their mental health needs and of their engagement in social, leisure and daily activities.

Summary of findings

The provider could not demonstrate that a robust complaints system was in place to listen and learn from people's concerns.	
Is the service well-led? The service was not well-led. People who used the service did not benefit from safe quality care, treatment and support from proactive management of the service. Quality monitoring systems were ineffective in ensuring people were protected from inappropriate and unsafe care. The provider could not demonstrate that quality monitoring systems were used to monitor and review incidents, concerns and complaints or improve and develop the quality and safety of the service.	**Inadequate** 

Cascade 4 - Newick Road

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 was unannounced and took place on 3 December 2014. The inspection was carried out by an inspector, inspection manager and a specialist mental health advisor.

We reviewed the care records for four people using the service and records relating to the management of the service. These included three staff files, records of complaints, incidents, audits and quality monitoring reports and minutes of residents meetings. We spoke with four people who used the service, the registered manager, deputy manager and a support worker and spoke with three professionals who had contact with people who used the service. We looked around the premises and observed lunch being prepared. We also reviewed information we held about the service, including records of incidents and any safeguarding concerns received prior to this inspection.

Inadequate

Is the service safe?

Our findings

We found serious shortfalls that compromised the safety and care of people who used the service. There had been a number of incidents that posed a risk to people's safety and risks to individuals were not proactively managed to ensure steps were taken to minimise these and protect people from harm. .

At the last inspection we found that the premises were not drug and alcohol free and that people who posed a potential risk to others continued to enter the property even though they had been banned from visiting. During this inspection we found that there were still visitors entering the premises who posed a risk to people using the service as they brought drugs and alcohol into the service which had a negative impact on people's mental health and their behaviour. These risks were known by staff and included in people's care plans. In particular some of the people using the service had a history of substance misuse which had caused a deterioration of their mental health. Staff had tried to manage this situation but this had not been effectively dealt with despite several calls to the police. When police were called the action taken was not sufficient to prevent recurring incidents. We saw from incident records that staff had on occasion had to remove themselves from situations to ensure their own safety and advise people to lock themselves in their bedrooms. During the inspection we witnessed people banned from the premises entering the service.

The provider failed to take action to prevent and minimise the risk of abuse. People who used the service were not protected from the negative impact of the behaviour of others. People shared their living environment with others who were regularly intoxicated or under the influence of illicit substances and who displayed outbursts of aggressive behaviour. We saw risk assessments relating to arson, physical and verbal aggression and harm from substance misuse, however, there were insufficient management plans in place to manage and minimise these risks. In relation to the behaviour of one individual, one person who used the service commented, "We haven`t exchanged any blows yet – its settled down now."

The rules of the house were clearly stated in the service user guide and included 'absolutely no drugs or alcohol allowed on the premises.' People had signed an acceptable behaviour agreement and were regularly reminded to adhere to house rules. Despite this one member of staff said there was, "considerable cannabis and alcohol use." People who used the service expressed concerns about the amount of drugs and alcohol used within the unit. One Staff member commented, "That leads to a lot of aggressive behaviour from clients." Another staff member said that the work was, "challenging at times due to the nature of the clients." We saw information that stated random drug testing was undertaken twice a week as a deterrent for drug taking, however, when asked staff told us that this did not occur.

A central incidents and accidents folder showed that there were 15 recorded incidents, four to which the police were called. In one incident on 29 October 2014 following the threatening behaviour of one person, a member of staff fled the premises and advised other people to lock themselves in their bedrooms at 7pm in the evening for their safety. This indicated that staff were unable to manage behaviour that challenged the service effectively in a way that promoted and protected people's safety. Police regularly visited the home in response to incidents, but their involvement had not been effective in reducing on-going incidents of threatening and anti-social behaviours. This included people inviting members of the public into the service who posed a risk to people using the service. These people had also on occasion put people in compromising positions that they found difficult to manage. Staff had been ineffective in responding to these situations and therefore people were at risk of harm.

Staff failed to identify safeguarding concerns and follow safeguarding procedures to protect people who used the service. At least three recorded incidents from the central incidents folder should have been reported as safeguarding concerns. Staff failed to involve other professionals to develop safeguarding plans and ensure people were protected. Following our inspection we notified the local authority about these incidents.

We found recorded incidents of on-going concerns that were confirmed by the staff we spoke with. Staff were unable to demonstrate that these incidents had been managed in a way that minimised future risks and promoted the safety of people using the service. One such concern involved a person taking food from the fridge and

Inadequate

Is the service safe?

freezer and selling it to people in the home for one pound. The Care Quality Commission had also received complaints from neighbours about people begging for money in the street.

Risk assessments were inadequate and did not protect people from harm. They did not sufficiently outline triggers and how to reduce risks and the records we saw were contradictory. This meant that staff were inadequately informed about how to manage risks to people who used the service and others. There was a lack of analysis or follow up action after incidents so that staff could learn from these to inform improvements to the care and support people received.

We found that some people using the service smoked cigarettes in their bedrooms, despite this being against 'house rules'. Risks relating to this had not been adequately assessed or managed. For example, people's rooms did not have smoke alarms fitted and staff advised us that people just opened their bedroom windows. This was a potential fire hazard that had not been fully considered or effectively managed to keep people safe.

The issues above meant there was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Standards of hygiene and cleanliness had not sufficiently improved since our last inspection. Although some deep cleaning had taken place and staff followed a cleaning schedule, some areas of the service were still not clean. The kitchen was particularly dirty; tiles on the kitchen work surfaces were cracked which meant they could not be effectively cleaned; the hob was covered in grease and dirty and inside the oven was very dirty, as was the fridge The lack of cleanliness and hygiene posed an infection control risk.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us there were enough staff to meet people's needs and said that there were a minimum of two staff on duty at all times. The rotas we looked at confirmed this, however, when we arrived at the service there was only one member of staff on duty who was the deputy manager. He told us that the other member of staff was running late. This member of staff arrived at the home an hour and a half later. Other staff did arrive at the home during this time to support the deputy manager with the inspection.

We looked at three staff files. All contained the required pre-employment checks such as criminal record checks, proof of identity, references and evidence of their employment history.

We checked the management and administration of medicines. All staff had received medicines training. Records showed that people who required support to have their medicines received their medicines safely, for example, there were no unexplained gaps or errors in medicines administration records. However, where people self-administered their medicines there were inadequate systems in place to ensure this was done safely. For example, risks relating to the storage of people's medicines and compliance with medicines had not been fully considered to ensure that the person and others were protected. We also found that people's care records contained contradictory information in relation to their compliance with medicines which meant staff did not have adequate guidance to ensure that people took their medicines as prescribed.

We also noted that staff had recorded that a person's mental health deteriorated a few days before they received their medicines but there was no indication that this had been discussed with their Community Psychiatric Nurse who administered the medicines to ascertain if a review of these medicines was required.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Inadequate

Is the service effective?

Our findings

Staff had not received adequate training to equip them with the knowledge and skills they needed to perform their roles and responsibilities. For example, staff were unable to demonstrate that they understood mental illness, the impact this had on people using the service and the support people required. Two members of staff told us that they had not received any training in relation to mental health or managing behaviour that challenged the service and said they thought this would help them to meet people's needs.

Training certificates were seen for fire, COSHH, food safety, infection control and health and safety. However, there was no specialist mental health awareness training to support staff in their role. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The provider could not show how the rights and choices of people who used the service were promoted. At our last inspection we found that the freezer was locked preventing people from helping themselves to food to prepare. We discussed this with the deputy manager who told us that this was because someone living at the service ate raw food that could cause them harm. However, we found no indication of this in the person's care records. When the deputy manager explored this further, we were told it was because someone had been selling food from the freezer. There had been no consideration of the impact this was having on other people or any discussions about Deprivation of Liberty Safeguards (DoLS) or consent in relation to this restriction that was imposed on people.

In addition we were told that the kitchen was locked after 11pm. Staff told us that some people were unhappy about this but again there had been no consideration of alternatives or how this restriction was affecting people. People's care records also contained details of restrictions imposed in relation to times of the day that people could leave the premises. However, there was no indication that this had been considered a deprivation of their liberty. Staff were unable to demonstrate an understanding of their responsibilities in relation to mental capacity and consent. They had not received training around the implications of the Mental Capacity Act 2005 and the provider had not considered the recent Supreme Court ruling that had broadened the scope of this legislation.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

At our last inspection we found that people's nutritional needs were not met. During this inspection we found that there was limited food available for people to eat. For example, the fridge was very empty and contained only some half empty bottles of table sauce, butter, two lettuces, less than half a pint of milk and a pepper.

We observed one person come into the kitchen to make a snack, using tomato ketchup to make a sandwich. We asked if that was what they wanted and they responded, "Some cheese would be nice." The deputy manager showed us some long life milk, sugar and coffee that was stored in the office upstairs. He said these could be taken down if needed. There was pasta and sauces and tinned soup and eggs, bread and some cereal available but no fresh fruit or vegetables. The deputy manager told us a delivery was due the next day and the fridge was usually bare the day beforehand. The deputy manager initially told us that there was no other food stored on the premises, however, he later returned from the office with a block of cheese that he said could be put in the kitchen. The deputy manager told us that food was stored upstairs to stop people eating too much. However, people's care records did not reflect this.

One person who was diabetic was not supported to meet their nutritional needs due to the lack of food choices available to them in the evenings. They told us they often went hungry and resorted to eating biscuits instead and staff did not act to address this. The person told us they did not wish to go upstairs at night and have to ask staff and therefore went without.

A cooked meal was prepared daily and recorded on a menu planner. Recorded meals included, lamb curry and rice, chips and burgers, stewed beef and salmon and vegetables. We observed lunch being prepared. This was chicken, chips and sweetcorn. People we spoke with told us they had "a lot of chips." We did not see staff ask people what they wanted, however records showed that people talked about their preferred meal options in their 'residents' meetings. We observed that the chips and sweetcorn had been dished up on to four plates, covered and left on the side. We asked a member of staff why this was and they said that the chicken was not ready and

Inadequate

Is the service effective?

needed longer in the oven. This meant that the rest of the food had been left to go cold. The staff member said they would put the plates in the oven to rewarm the food. This was not following safe food handling practices.

There was insufficient evidence to show that people were being encouraged to make healthy living choices concerning diet, exercise and lifestyle.

The above issues relate to a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People's day to day healthcare needs were met. We saw some health appointments recorded such as dentist and GP appointments.

We could see from the three staff files we looked at that regular supervision sessions were taking place with staff and their line manager and annual appraisals were also taking place.

Is the service caring?

Our findings

Whilst people expressed their views in their one to one meetings, staff did not always act in a way that demonstrated that people's views were listened to, understood and acted upon. Staff did not seek to understand the underlying reasons for people's low levels of motivation and to find creative ways to support them. One person repeatedly expressed concerns about their mood in their one to one meetings. However, records of their one to one meetings and their care plan frequently stressed low motivation without explicitly recording how this would be tackled.

Staff told us people did not wish to do anything and people's levels of motivation and general standards of personal care were very low. This was confirmed by our observations. However there was insufficient evidence to demonstrate how the service provided a supportive environment for people in a way that helped maximise their opportunities and potential to support them to achieve their individual goals and aspirations. One professional told us they had some concern that staff appeared not to be proactive in the way they supported people.

Staff did not have good knowledge of people's needs or how to meet these. Information staff gave us contradicted what was in the care plans and staff had to check with other staff to get information.

We received mixed feedback from people who used the service about staff engagement with them. One person said "Staff are alright. It's hard for them to deal with people here sometimes." Feedback we received from one person appeared to reflect our observations, who said staff were not at all encouraging, and "some are not very good." One person who used the service had contacted the Care Quality Commission about being poorly treated by an individual member of staff, which led to a safeguarding alert being sent. This also reflected the view of another person in their one to one record, who reported being concerned about staff engagement with them. There were no records of any action taken in response to this. People did not have access to advocacy services.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Care records had been updated since our last inspection. They included a mental health recovery support plan, however, none of these had been signed by the person using the service or a representative to demonstrate people's involvement in their care planning.

We observed staff interact in a way that was kind and caring and that people were comfortable in their interactions with staff. Staff spoke with people in a respectful manner and observed their privacy by not entering their rooms without their permission.

We asked staff about how other issues concerned with equality and diversity were

accommodated. Although few people living at the home required special provision staff were aware of the need to make special provisions when it was appropriate to do so. Staff told us about the facilities available locally for people from different backgrounds and that dietary preferences were taken into account in respect of the meals provided. One individual who used the service confirmed that staff prepared meals to suit their cultural preferences.

Is the service responsive?

Our findings

The provider could not demonstrate that there were arrangements in place to regularly review and assess people's individual needs. There was a lack of joint working with health and social care professionals who were involved in the care, monitoring, and review of people who used the service. At our last inspection we found that reviews had not been held with health and social care professionals to ensure that people's needs were met. During this inspection we found there was still a lack of partnership working with mental health specialists to ensure that care plans were developed that were responsive to people's needs.

The deputy manager advised that all the care teams had been contacted to arrange reviews since the last inspection and three individuals had reviews after a long overdue period. The registered manager and staff were not aware of how many people were on the Care Programme Approach (CPA). This was where professionals met to assess and plan ways to support and provide appropriate care to people with mental health needs. The manager believed three people had been taken off their CPA but could not say when or why and there were no records to substantiate this.

We were concerned about the lack of timely reviews for people, to assess their progress and wellbeing; to encourage the prevention and early detection of ill health and consider changes in their needs. Whilst contact had been made with all the care teams for people who used the service, the reviews of people had been long overdue and not all individuals had their care and mental health needs reviewed. Professionals we spoke with had some confusion about who was responsible for the care and review of people who used the service.

Whilst care plans had been revised and updated using the 'Recovery Star' tool, they still lacked sufficient detail about people's individual needs and how these should be met. Care files were still disorganised and although Recovery Star was now in place for all people using the service, this information was incomplete in some of the care plans or lacked sufficient detail in areas including individual wishes and preferences, actions, and immediate and longer-term goals. For example, the action linked with one person's need was vague referring only to their issue being discussed with the person. There were no strategies or guidance for staff to know how to address this need. In addition multiple care plans were in use increasing the risk of confusion about people's needs and how best to support them.

We found inaccurate information in people's care plans. For example, in one it stated times a person should not be allowed out as they engaged in behaviour that was harmful to them. When we discussed this with staff, they said this was inaccurate.

Care plans contained very little evidence of any social or leisure engagement. Despite entries that stated people were interested in photography, going to the gym and painting, there was no evidence that any of these activities were taking place. One person told us that they used to enjoy going to the cinema and going out to eat but that this didn't happen anymore. The service user guide stated 'structured day time programmes form an important part of your care plan' and said 'doing nothing' is not an option.

One person who used the service advised, "There is nothing to do." Another person told us they were learning to cook with assistance from staff. They said that they had enough support and, "If I need it I can ask for it." A staff member stressed the need to take a "different approach for each person." They gave an example of how they had successfully encouraged a person to go to a local church.

One person had recently enrolled on a cooking course and another attended religious services that met their spiritual needs and groups of their choosing each week. However where goals were identified in people's care plans, such as improve budgeting skills and going to college, many of the daily notes just stated that people did not want to participate in any activities. Where this was the case we found no evidence of any plan to encourage and motivate people. For example, the notes of one person who wished to go to college stated they, 'had changed their mind and wanted to leave it for a year' due to the person, 'not feeling up to it.' There were no plans, assessments or evidence to show how the person was being supported with this or how their mental health needs were being addressed. The deputy manager told us that people did not have any pre-arranged appointments or activities and said that people "just get up and go out when they want."

Daily observation notes were brief and lacked any evidence of positive engagement with people using the service. Staff

Is the service responsive?

wrote notes for the monthly key work meetings they had with people, but the information was identical in some of the records and did not correspond with what was in people's care plans.

Individual progress reports indicated little change over time to help people meet their aspirations. We found no evidence of consideration of alternative approaches or referral to others sources of expertise. For example, concern about one person's substance misuse had been recorded over a number of years. Recent reports indicated there had been no improvement.

Feedback from people was mixed about responses from staff and the care they received. Some said they were happy living at the home and did not want much intervention from staff. Others were unhappy with the level of support available and one person said it was "alright", but they could not understand why they had remained living at the home for many years when they expected to be there for a few months.

The issues above demonstrate a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Information about how to make a complaint was displayed on a noticeboard by the kitchen. This included a copy of the complaints policy and leaflets for people to complete. There was also a service user guide attached to the notice board and in it was a sentence in several different languages that said the guide could be translated if required.

One person who used the service advised that his complaints about another person in the home were not appropriately addressed. This person stated, "I have been here since…It has got worse." People were able to make their views known to staff however records of meetings did not always show evidence that staff responded to the concerns raised by people.

We looked at the complaints log. There were two complaints from neighbours about abusive language and people trying to sell drugs to them. The manager had responded to these complaints and had spoken with the neighbours advising them to call the police if there were any further concerns. However, there was no information to state what action was going to be taken by staff to address the issues raised. There was no evidence of learning from complaints.

Is the service well-led?

Our findings

People who used the service did not benefit from safe quality care, treatment and support. There were repeated incidents aggression affecting the safety and wellbeing of people who used the service and there was no evidence that appropriate action was taken to manage this and support staff.

Quality monitoring systems were ineffective in ensuring people were protected from inappropriate and unsafe care. Audits were used to ensure staff followed systems and procedures in place, including health and safety checks, medicines audits and cleanliness checks. However, these were ineffective as they had not identified the shortfalls we found during our inspection.

The senior management team advised us that a member of their team had visited the service following concerns identified at the last inspection. They had carried out an audit and looked to see if actions had been carried out. This was confirmed by the deputy manager we spoke with. The senior manager had reported back that all actions had been carried out, and told us they were therefore not aware of the extent of the concerns we found at this inspection.

The senior management team conducted unannounced visits every three months to carry out further audits and produce a quality audit report. These reports included comments about work carried out and any outstanding actions. In addition, the manager of the service had completed an annual report in the last year. We saw that some analysis and recommendations for action were made in this report. For example, a recommendation was made that people had regular key working sessions and progress reviews. A number of actions were highlighted, such as the need to arrange one to one meetings with people for them to gain more confidence and explore more community based activities.

However there was a lack of critical analysis in any of the management audit reports about the effectiveness and quality of the service in order to improve the overall outcomes for people and their experience of using the service. The provider could not demonstrate that audits and quality monitoring systems were used to improve the quality and safety of the service.

The provider could not demonstrate how they took into account information from all relevant sources in the on-going development of the service, including feedback from people who used the service or others acting on their behalf; observations; individual progress reports and incidents that resulted in or had the potential to harm people; comments and complaints and professional best practice guidance. We spoke with two senior managers of the organisation who told us that they were unaware of a number of serious incidents as these had not been reported to them. However the incidents had also not been picked up in any senior management audit report or other intervention. This meant that people were less likely to be protected.

Monthly resident and one to one meetings took place where people could express their views. However records seen did not always demonstrate that staff took action to address the issues raised by people. Management audits of quality failed to identify this to improve the service people received and ensure the service was responsive to their needs.

There was a lack of management action to ensure policies and procedures were implemented. For example, to ensure staff used safeguarding procedures in response to safeguarding concerns; ensuring incidents affecting the safety and welfare of people were reported to senior management; enforcement of house rules; ensuring risk assessments were updated following incidents or evidence that reviews took place in a timely manner.

The evidence above relates to a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The provider failed to ensure that the Care Quality Commission was notified of significant incidents affecting the safety and welfare of people using the service such as safeguarding concerns. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that staff employed to carry out the regulated activity received appropriate training, professional development and support. Regulation 23(1)(a)**

Regulated activity	Regulation
	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had failed to notify the Care Quality Commission of significant incidents where any abuse or allegation of abuse took place or where incidents were reported to the police. Regulation 18(1)(2)(e)(f)
	The registered person had not made suitable arrangements to ensure that service users were treated with respect and consideration at all times. Regulation 17(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe as they had not planned or delivered care in a way that met their individual needs or ensured their welfare and safety. Regulation 9(1)(b)(i)(ii)

The enforcement action we took:
A warning notice was issued, the deadline for addressing the breach of regulation was the 30 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not protected service users and others who may be at risk, against the risks of inappropriate or unsafe care as there were ineffective systems for assessing and monitoring the quality of services provided and for identifying, assessing and managing risks to service users and others. Regulation 10(1)(a)(b)(2)(a)(b)(i)(iii)(iv)(c)(i)(d)(e)

The enforcement action we took:
A warning notice was issued, the deadline for addressing the breach of regulation was the 30 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure that service users were protected against the risk of abuse as they had not taken steps to identify the possibility of abuse and prevent it before it occurred and had not responded appropriately to allegations of abuse. Regulation 11(1)(a)(b)(3)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
A warning notice was issued, the deadline for addressing the breach of regulation was the 30 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person had not ensured service users, persons who were employed or others who may be at risk of exposure to a health care associated infection were protected against identifiable risks of acquiring such an infection as appropriate standards of hygiene and cleanliness were not maintained. Regulation 12(1)(a)(b)(c)(2)(c)(i)

The enforcement action we took:
A warning notice was issued, the deadline for addressing the breach of regulation was the 23 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person had not ensure that service users were protected from the risks of inadequate nutrition and hydration as they did not provide a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs. Regulation 14(1)(a)

The enforcement action we took:
A warning notice was issued, the deadline for addressing the breach of regulation was the 23 January 2015.