Care Quality Commission

Bretton Care Limited

Bretton Care

Inspection report

3 Mauds Terrace
Monk Bretton
Barnsley
South Yorkshire
S72 2EA
Tel: 01226 496212
Website: www.brettoncare.co.uk

Date of inspection visit: 1 and 3 October 2014
Date of publication: 11/06/2015

Ratings

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

Overall summary

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 was 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. 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.

This inspection took place on 1 October 2014 and was unannounced. A further visit took place on 3 October 2014. The two people who lived at the service did not wish to speak with the inspection team about their experiences of living at the service. Each person was supported in a separate property and during the inspection we looked at the individual properties. We had spoken with one person who lived at the service during our inspection on 10 June 2014 and at that time they were positive about the care they received.

Summary of findings

At our previous inspection on 10 June 2014 we identified a breach of regulation 11 safeguarding people who use services from abuse, regulation 23 supporting workers, and regulation 10 assessing and monitoring the quality of service provision of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if those improvements had been made. We found continued breaches in regulation 23 supporting workers and regulation 10 assessing and monitoring the quality of service provision. You can see what action we told the provider to take at the back of the full version of the report.

Bretton Care provides accommodation and personal care for up to six people who are care leavers who have a range of learning disabilities including challenging behaviours. The service has not had a registered manager since 10 April 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. A manager was employed at the service and had made an application to become the registered manager.

The service had not identified, assessed and managed risks relating to the health, welfare and safety of people and others who may be at risk from the carrying on of the regulated activity. For example, we identified risks to people associated with the environment such as fire, window openings and water temperatures. We also identified individual risks to the people living at the service presented in terms of their welfare and safety. You can see what action we told the provider to take at the back of the full version of the report.

People were supported to make choices and care staff had received training in safeguarding to provide them with the knowledge to protect people from potential abuse and they said they were aware of the procedures to follow to report abuse.

Two members of care staff were on duty at all times providing 24 hours support to the two people who lived at the service. This was not one to one support at all times meaning that people who lived at the service were not under constant control and supervision. This was to ensure that care staff were available to support people at all times.

The recruitment of care staff did not evidence that all the required pre-employment checks and documents as set out in the regulations were in place. You can see what action we told the provider to take at the back of the full version of the report.

Whilst the service were aware of people's health and care needs, care staff did not always have the sufficient training, skills and experience to ensure they managed the risks people who used the service. External health and social care professionals were working closely with care staff to support them to develop these skills and provide a consistent approach to people living at Bretton Care.

The manager was conversant with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), but care staff lacked understanding about how it might apply to people who used the service and in their role.

People who used the service were provided with a weekly allowance for shopping and encouraged to be independent with this and with aspects of their care such as preparing and eating meals of their choice.

People's support plans were not reviewed when needed, resulting in support plans being out of date and not reflecting people's current needs. This put people at risk of inconsistent and/or not receiving the support they need. You can see what action we told the provider to take at the back of the full version of the report.

Care staff knew people's life history, likes, preferences and needs. Discussions with care staff evidenced they cared for the people who used the service. Care staff provided people with opportunities to express their views and listened and acted on this information.

People were encouraged to give their views and raise concerns or complaints. The matters they raised were dealt with in an open, transparent and honest way.

At the time of our inspection leadership of the service was reactive, and not proactive. The registered provider did not have the knowledge, skills or experience to carry on the regulated activity. There had been no registered

Summary of findings

manager since 9 April 2014. Legal obligations, including those placed on them by other external organisations were not always understood and met. Quality assurance systems were in place, but were not sufficiently robust to identify, assess and manage risks. You can see what action we told the provider to take at the back of the full version of the report.

Care staff told us they were happy in their work, motivated and confident in the way the service was managed. They said, “everything’s loads better since [manager] came” and “I feel safer now than I did. It’s better now because we have policies and procedures we can refer to. There’s been a big improvement with training”.

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.

The service had not maintained a safe environment to safeguard people from risks associated with fire, window openings and water temperatures. The risks presented by people were not always managed well, which meant the safety of care staff and others was compromised.

Not all the specified documentation to confirm if all the pre-employment checks had been carried out for the recruitment of care staff was available in their files as required by the regulations.

People were supported to make choices and take risks and care staff had received training in safeguarding to protect vulnerable adults from potential abuse and said they were aware of the procedures to follow to report abuse.

Sufficient numbers of care staff were available to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The service were aware of people's health and care needs, but care staff did not always have the sufficient training, skills and experience to ensure they managed the risks associated with the care of people who used the service.

Deprivation of Liberty Safeguards (DoLS) and the key requirements of the Mental Capacity Act (MCA) 2005 were not fully understood by care staff, despite them attending training.

People who used the service were provided with a weekly allowance for shopping and encouraged to be independent with this and preparing and eating meals of their choice.

Is the service caring?

Good

The service was caring.

Care staff knew people's life history, likes, preferences and needs. Discussions with care staff evidenced they cared for the people who used the service. Care staff provided people with opportunities to express their views and listened and acted on this information.

Is the service responsive?

Inadequate

The service was not responsive.

People's support plans were not reviewed when needed, resulting in support plans being out of date and not reflecting people's current needs. This put people at risk of inconsistent support and/or not receiving the support they needed.

People were encouraged to give their views and raise concerns or complaints. The matters they raised were dealt with in an open, transparent and honest way.

Summary of findings

Is the service well-led?

The service was not well led.

At the current time leadership was reactive, rather than proactive. The registered provider did not have the knowledge, skills or experience to carry on the regulated activity. There had been no registered manager since 9 April 2014. The service did not have a clear vision about the type of service they wished to provide. Legal obligations, including conditions of registration from CQC, and those placed on them by other external organisations were not always understood and met. Quality assurance systems were in place, but were not sufficiently robust to identify and manage risks.

Care staff told us that they were happy in their work, motivated and confident in the way the service was managed.

Inadequate

Bretton Care

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.

This inspection took place on 1 October 2014 and was unannounced. A further visit was made on 3 October 2014. At the time of the inspection two people were living at the service. The service had agreed a voluntary embargo with the local authority until the local authority were assured the registered providers could provide a quality service to the people who used the service. The people who lived at the service chose not to speak with the inspection team about their experiences of living at the service. Each person was supported in a separate property and during the inspection we looked at the individual properties. We had spoken with one person who lived at the service during our inspection on 10 June 2014 and at that time they were positive about the care they received.

During our inspection we spoke with the manager and three members of care staff. We also reviewed the support plans and medication records of each person living at the service. We looked at documents about the quality assurance process and how the home was managed as well as records relating to the recruitment, training and supervision of two members of care staff were also reviewed.

The inspection team consisted of two adult social care inspectors.

Before our inspection, we reviewed the information we held about the home. This included correspondence we had received about the service and notifications submitted by the service. We also spoke with four external professionals who had knowledge of Bretton Care. This information was reviewed and used to assist with the planning of our inspection.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return the PIR. We asked them about this during our inspection and they provided evidence they had returned it to the Commission before the date required and provided a copy. We considered this information after the inspection.

Inadequate

Is the service safe?

Our findings

At our inspection on 10 June 2014, we identified a breach of regulation 11, safeguarding people who use services from abuse of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the registered person to send us a report outlining how they would make improvements.

We looked at how the service protected vulnerable adults from the risk of abuse. We found there were policies and procedures in place that were aligned with the South Yorkshire safeguarding adults authority protocols. Care staff told us and records confirmed they had received training in safeguarding vulnerable adults. Care staff we spoke with were able to describe how they would recognise abuse and told us they felt confident to report any concerns they had.

The manager told us and care staff confirmed the service did not support people to manage their finances. We saw that safes had been bolted to the floors of people's bedrooms to enable people to safeguard their monies.

We found the systems in place to manage risks to individuals and the service were ineffective and placed people and others at risk of potential harm. For example, the manager told us that non-physical, de-escalation techniques were used to keep people and others safe. This was confirmed by staff when we spoke with them. They told us weekly workshops from health professionals were taking place to discuss and review incidents. Some staff had also received training about behaviours which may challenge from an external training provider. Staff were positive about these sessions and told us that they had enabled them to better understand and support people.

Our review of incidents in September 2014 identified that there had been incidents of self-harm and/or threatening behaviour which placed both people and members of care staff at risk. De-escalation techniques were used to respond to these situations. However, this was not having a positive effect on the management of the behaviour that challenged. In addition, the incidents were increasingly placing staff and others at risk of harm.

We reviewed a copy of the provider's policy document about the prevention and management of violence and aggression to confirm staff were following the service's agreed protocols. The policy document stated that members of staff could use physical intervention to lessen risk, in the event of de-escalation techniques not being effective. Situations where it may be appropriate to use physical interventions to reduce risk to people and others were listed within the policy document. These included: physical assault, self-harm and other behaviours which were deemed threatening and/or dangerous. This meant the service were failing to follow their own policy about the prevention and management of violence and aggression to protect people and others from risks associated with that behaviour.

In addition, a 'resident's behaviour charter' was in place. This defined the expectations / behaviours of the service and what would happen if people failed to meet these. Our review of incidents showed us that people had continually breached this charter. No action had been taken by the provider in response to these breaches. This meant that the provider had failed to apply the actions stipulated within their own charter document to protect people and others from the risks associated with behaviour that challenged.

We reviewed people's support plans and risk assessments to check they had been updated as a result of the increasing number of incidents in September 2014 which placed people and others at risk. We found that they had not been updated to reflect people's increased needs. Additionally, a stakeholder informed us that Bretton Care had failed to implement the behavioural tools they had provided in order to document the possible triggers for people's behaviour to inform and support the development of consistent behavioural approaches and strategies. The provider's failure to appropriately assess and update records relating to risk and assist in the development of appropriate guidance meant that people were placed at risk of unsafe care and treatment.

Our review of records identified that people who used the service could pose a risk to themselves. We found a first floor window of one person's bedroom open beyond 100mm. This failed to follow published guidance from the Department of Health as detailed in the Health Technical Memorandum HTM 5. A window restrictor had been attached to the window but had been defeated by the person. The manager was aware of this but had failed to identify and take corrective action to protect people from the risk of harm.

We identified that an action plan to protect a member of staff had not been consistently implemented. The action

Is the service safe?

plan stated that the staff member should not work alone, with one person who used the service. Our review of records showed they had continued to work alone and that incidents placing them at risk had continued to occur. The provider had informed the staff member concerned that a debrief section would be added to the incident forms and that they would speak with the person who posed a risk to their safety. Our review of the incident forms for September 2014 identified that this debrief session had not been implemented and the manager could not confirm a discussion had taken place with the person about their behaviour. Additionally, there was no information in the person's support plan to document how staff should support them to manage any behaviours which may challenge, or pose a threat to others or guidance for staff about how to keep themselves safe.

A fire risk assessment undertaken by an external contractor had identified that appropriate systems were not in place to reduce the risk of fire. A plan detailing the actions needed to ensure fire safety had been provided by the external contractor. Our review highlighted that the provider had yet to complete a number of the actions listed within this plan. The manager informed us that a further fire survey had been booked for the service on 10 October 2014. This meant the registered provider had failed to manage risks to the service to protect people and others from harm.

During our inspection we identified a number of other environmental safety checks had not taken place within the provider's specified timescales. For example, shower descaling had not taken place within the identified frequency and the weekly monitoring of water temperatures did not reflect 'Controlling legionella in nursing and residential care homes', a guidance document published by the Health and Safety Executive. This documents states that 'water coming out of taps above 44 degrees centigrade presents a risk of scalding'. Our review of temperature checks identified that hot water running from the baths within the two properties in use at the time of our inspection was above this safe level.

Furthermore, the health and safety checklist dated 8 September 2014 stated portable appliance testing was in place. We asked the manager for certification, which she was unable to provide.

Our findings evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager told us that two members of care staff were available throughout 24 hours to support people who lived at the service. This meant care staff were available to support people at all times. We were told agency care staff were only used in emergencies when cover could not be facilitated within the care staff team, so that continuity of care staff could be provided for people who used the service. An on-call system was in place for care staff to obtain additional support if necessary. Discussions with staff and inspection of staff rotas and handovers confirmed this.

We looked at how the service managed people's medicines. We found there was a medication policy/ procedure in place. We spoke with care staff about the system in place to manage people's medicines, including medicines that were administered to people 'when needed'. We reviewed MAR (medication administration record) sheets and found there were handwritten entries identifying changes to one person's medication. There was no documentation either on the MAR, or in the person's support plan/care file to evidence when the directions for medication had been changed, or by whom as described by staff.

We looked at how the service recruited staff. We found the recruitment policy dated 14 July 2014 did not reflect the documents and checks that are identified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Schedule 3 is a list of pre-employment checks and documents that must be in place to confirm the effective recruitment of care staff.

Three members of care staff had commenced duty since the last inspection. We checked two staff files to confirm the pre-employment checks and documents were in place. In one file, there was a Disclosure and Barring Service (DBS) check, but there was no record to confirm a further check had been made at the time of the staff member's appointment, so that they continued to be safe to work with vulnerable adults. Additionally, there were gaps in the person's employment history and satisfactory evidence to demonstrate that previous relevant employment within adult social care was satisfactory was not in place. In a second file, the place and dates of the staff members

Inadequate

Is the service safe?

previous employment could not be clarified as their employment history did not correspond to references within their file. There was no evidence to demonstrate that this had been verified at interview. This meant

Our inspection findings evidenced a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

At our inspection on 10 June 2014, the registered person did not have suitable arrangements in place for care staff to receive appropriate training to enable them to deliver care and treatment to people safely and to an appropriate standard. This was a breach of regulation 23 supporting workers of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the registered person to send us a report outlining how they would make improvements.

During this visit we checked to see if those improvements had been made. We found there had been some improvements in the training of care staff in order to provide them with the necessary skills and knowledge to fulfil their role. From discussions with care staff and our review of the training matrix we noted that this training included: fire safety, health and safety, infection control, safeguarding of vulnerable adults, manual handling/ moving and handling, medication, behaviour that challenges, food safety, first aid and training about the Mental Capacity Act. However, there were still gaps in the training individual care staff had received and the training undertaken for behaviour which may challenge had not been effective in practice. This meant on some shifts there were staff working with vulnerable adults that did not have the appropriate training to deliver care to people safely and to an appropriate standard.

People using the service had behaviours which challenged and mental health needs. Those needs included self-harm associated with their mental health. We found that the staff at Bretton Care had not received training relating to people's the individual needs of people who used the service. This meant that staff had not been supported to enable them to deliver care and treatment to people safely and to an appropriate standard.

When we spoke with care staff they told us that, since the appointment of the new manager, they had received more training. They said they felt supported in their role and were confident they had the knowledge and skills to support people who used the service.

Care staff told us they received supervision meetings and valued the support.

Meetings were being held between the registered providers and stakeholders because of concerns about the service's ability to provide quality support to the people who lived there. Whilst they felt the support provided stability for people who used the service they felt that the service was not always equipped with the necessary skills to effectively support people.

This meant the registered provider continued to be in breach of regulation 23 supporting worker of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how consent to care and treatment was sought in line with legislation and guidance. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests and that the least restrictive option is taken. The manager was aware of a recent change in DoLS legislation. The manager told us that she had considered the recent changes in the DoLS legislation and no-one living at the home was being deprived of their liberty. The manager was also aware of the role of the supervisory body in relation to the DoLS.

People's support plans, daily reports, notifications and discussions with the manager and care staff confirmed that people were not being deprived of their liberty. We saw evidence that people were not deprived of their liberty through support plans, daily reports, notifications and discussions with the manager and care staff.

The manager was aware of the requirements of the Mental Capacity Act and referred to assessments of people's capacity to make decisions and the need for 'best interest' meetings to be held for people who lacked capacity. She was aware of the role of Independent Mental Capacity Advocates (IMCAs) and how they could be contacted.

Care staff we spoke with had received training in MCA/DoLS and it had been discussed at a team meeting. Care staff were able to demonstrate some understanding of the principles of the MCA and DoLS and understood if people had capacity, they made their own decisions, even if the decisions they made were unwise decisions. People's capacity to make decisions can fluctuate, for example, when they are unwell. Given the needs of people supported by Bretton Care there was a risk that this lack of knowledge may place people at risk of receiving unsafe care and treatment.

Inadequate

Is the service effective?

People's support plans showed that people had access to healthcare professionals, such as GPs when needed. We were told by a GP that people did not always attend appointments and reasons for this non-attendance were not given. We fed this back to the manager. They said this may have happened in the past and informed us that they had recently developed a procedure which stated that the surgery should be contacted to explain the nonattendance and that this should also be recorded in the person's support plan.

People who used the service were provided with a weekly grocery allowance by the provider to shop for food and drinks of their choice. This demonstrated that people were encouraged to be independent in all areas of their own meal choices. When we spoke with care staff they explained that they promoted a healthy diet for the people who used the service. On the day of the inspection we saw one person returning from a shopping trip and putting away the food they had bought.

Good

Is the service caring?

Our findings

Discussions with the manager and care staff demonstrated from their perspective how they had developed positive relationships with people who used the service and their families. The manager and care staff we spoke with thought the staff team were approachable and the aim of the service was to enable people to feel valued. During our discussions with care staff it was evident they had a caring approach to people who used the service. Care staff demonstrated familiarity and knowledge of people's likes and dislikes. When we spoke with them they spoke about people in a caring and thoughtful way. They demonstrated this by their knowledge of people's personal histories and being non-judgemental about that. Their discussions identified how they respected the person and the choices they made in life, whilst at the same time encouraging them to make choices that were more wise, to protect them from harm and improve their quality of life.

The manager and care staff told us they aimed to promote choice in all aspects of daily living for people who used the service. Care staff told us people were given options about things they wanted to do during the day, where they wanted to go and what they wanted to eat amongst other things. This was confirmed when we looked at people's daily journals. This showed that care staff listened to what people said and meant that people had opportunities to influence what their preferences were in relation to their care and support. Care staff also told us they sought people's views constantly on a one to one basis to ensure they were actively involved in their own care and support.

We saw that people had personalised their properties according to their own taste and choices, familiarising their environment with items they wanted around them.

Inadequate

Is the service responsive?

Our findings

We looked at how the service met people's needs and how they responded to any changed needs in a timely way.

The manager told us that all the people who used the service had been placed at the home in an emergency. At the time of these admissions the providers statement of purpose said that they supported people who had a learning disability and/or autism spectrum disorder. The primary needs of the two people admitted to the service did not match this statement of purpose, meaning that people had been admitted to the home, with needs that were outside the scope of the service. At the time of our inspection the service were still in the process of training and equipping care staff to meet the needs of people living at Bretton Care.

Each person had a support plan in place, as well as a daily journal to record what had taken place during the day. We looked at both people's support plans. Discussions with care staff and reviews of these people's daily journals identified their support plans did not contain important specific information about the support people required. Additionally, the support plans had not always been reviewed and updated when there had been changes to people's needs, for example, changes to people's medication were not recorded and incidents of self-harm had not been reviewed.

There were specific situations recorded within people's support plans where it had been agreed that restrictions could be placed on a person as a result of the risk they presented. People had capacity and care staff told us these restrictions had been agreed with the individual so that they had as much control and autonomy as possible, whilst at the same time, minimising risks for themselves and others.

We received information from a GP that health appointments for people who used the service had been missed without any reason being provided. We saw some records of visits to health appointments, but the service could not consistently demonstrate from people's records what health appointments had been made, whether they had been attended or not, the outcome of these appointments, and whether the support provided needed to change as a result of those interventions. This meant we were unable to see evidence that the service was being responsive to people's healthcare needs by making sure ongoing referrals were made, and that when people didn't attend appointments, health professionals were informed and the reason for non-attendance noted. For example, one person had made two visits to the hospital. A recommendation was made for the person to refer themselves to another service so they could receive appropriate support. There was no written evidence to show that this referral had been made, or if not, the reason for this.

Our inspection found evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager told us that, since their appointment there had been no formal complaints. Our review of the complaints file confirmed this. We saw evidence that the home's complaints procedure was discussed and shared with people who used the service, and that a copy was placed in their support plan.

Inadequate

Is the service well-led?

Our findings

At our inspection on 10 June 2014, we found the registered person did not have operational systems in place to regularly assess and monitor the quality of the service and identify, assess and manage risks relating to the health, welfare and safety of people who may be at risk from the carrying on of the regulated activity. This was a breach of regulation 10 assessing and monitoring the quality of service provision of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the registered person to send us a report outlining how they would make improvements. However, during our inspection on 1 and 3 October 2014 we found that whilst there had been improvements with the identification, assessment and management of risks relating to the health, welfare and safety of people using the service and others we found they had been ineffective in practice. This meant the registered provider had not had regard to the report prepared by the Commission relating to compliance with the provisions of these regulations as part of an effective quality monitoring system.

The registered provider did not understand their responsibilities in regard to the carrying on of the regulated activity of accommodation for people who require personal care. A regulated activity is the type of service the registered provider provides.

In addition, there had been no registered manager since the previous manager's resignation on 9 April 2014. The new manager commenced employment on 5 August 2014, but had been providing guidance and support to the service before this date. The manager provided evidence they had submitted an application to become the registered manager, and discussions with them demonstrated that they knew what was required of a registered manager as they had been a registered manager at a previous location. They were committed to providing a good service and making improvements. They explained they were not fully aware of the improvements needed on their appointment and were working hard to make them, but said, "there was so much to do". They identified their biggest challenge as "walking into a service where everything was wrong and finding a baseline to work from". They explained that they had prioritised the safety of people who used the service and then explained to care staff why changes had been made.

The manager was in the process of obtaining supervision from an external consultant as the registered provider did not have the training, skills or experience to support them in their role. This meant that currently there was no oversight of the service to identify whether a good service was being provided and to recognise areas for further improvement.

We spoke with the manager about improvements that had been made. She explained her biggest achievement so far had been the implementation of policies and procedures, so that care staff had a process to follow. The manager explained that a quality assurance system was now in place, although all the necessary audits had not been completed due to having to prioritise other tasks and react on a daily basis to situations presented by people using the service.

The pharmacist we spoke with had worked with the manager at a previous registered service and said she did a good job developing that service.

We spoke with a stakeholder of the service who told us they found the manager open and honest and that she was working hard to put systems in place systems to improve the service.

When we spoke with care staff they were positive about the new manager. They said, "everything's loads better since [manager] came" and "I feel safer now than I did. It's better now because we have policies and procedures we can refer to. There's been a big improvement with training".

We found the manager had implemented a quality assurance policy. The policy document included checks and audits relating to the needs of people supported by the service, staff and the environment. For example, it included: incident monitoring, workplace risk assessments and risk management plans and internal audit systems for monitoring compliance including, water, health and safety, medication and care plans.

During our inspection we found that the above systems had not been effective in identifying, assessing and managing risks to people and others. For example, we identified that an action plan to protect a member of staff had not been consistently implemented. The action plan stated that the staff member should not work alone. Our review of records provided evidence that they had continued to work alone and that incidents placing them at risk had continued to occur.

Inadequate

Is the service well-led?

We identified that a fire risk assessment undertaken by an external contractor, had identified that appropriate systems were not in place to reduce the risk of fire. An action plan detailing the actions needed to ensure fire safety had been provided by the external contractor, but our review highlighted that the provider had yet to complete a number of the actions listed within this plan, continuing to place people and others at risk of harm. This identified there had not been appropriate systems in place to manage fire safety.

We also identified a number of other environmental safety checks had not taken place within the provider's specified timescales, for example, shower descaling, which meant people and others were at risk associated with legionella. In addition, weekly monitoring of water temperatures did not reflect a guidance document published by the Health and Safety Executive that states 'water coming out of taps above 44 degrees centigrade presents a risk of scalding'. This meant the checks in place had failed to recognise the water temperatures presented a risk to people's health, welfare and safety and appropriate action taken to rectify or manage the risks.

The quality assurance system included medication checks. Our findings also demonstrated that this was not effective in practice. This was because the medication audits which had been undertaken had failed to identify our findings and the improvements needed to ensure that medicines were managed safely.

The training matrix was how staff training was audited. The training matrix identified gaps in training and this had not been acted on in a timely way continuing to place vulnerable people at risk of being cared for by staff who may not have the appropriate training, skills and knowledge to care for people safely and to an appropriate standard.

Our findings from this inspection identified the service continued to be in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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.