Clearwater Care Group Limited

Brightlands

Inspection report

77 Main Road,
Hoo,
Rochester,
Kent
ME3 9AA
Tel: 01634 250592
Website: www.clearwatercare.co.uk

Date of inspection visit: 13 October 2015
Date of publication: 30/12/2015

Overall summary

We inspected this home on 13 October 2015. This was an unannounced inspection.

Brightlands is registered to provide accommodation and personal care for up to 13 people with a learning disability. Each person who lives in the service is provided with en-suite facilities for their own use. Accommodation is provided over three floors and there is a stair lift to the first floor only. People who lived in the home had learning disabilities, some with communication difficulties, physical disabilities and challenging behaviour. At this inspection we found that there were 10 people living in the home.

At our last inspection on 26 February 2015, we found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not followed specialist guidance on feeding one person. We requested the provider to submit an action plan on how and when they planned to improve the service. The provider submitted an action plan to show how they planned to improve the service by 06 July 2015.

We inspected the home against four of the five questions we ask about services: is the service safe, effective, responsive and well led.

Prior to this inspection we received information of concern in relation to care practices at the home. This included whistleblowing information that had not been investigated and poor staff practice. In addition, concerns had been raised about lack of consistency of records, incidents that were not reported to the local authority and notifications that had not been sent to the commission to tell us about incidents and accidents in the home.

There was a registered manager at the home. 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.

Medicines had not been properly managed. Not all staff were trained and allowed to give medicines, and people did not always receive their medicines in a timely manner, to meet their needs.

Brightlands had a safeguarding policy. They also had a copy of the local authorities safeguarding adult's policy, protocols and guidance. However, the registered manager had not followed the local authorities safeguarding policy, protocol and procedure. The registered manager had not appropriately deployed staff to meet people's needs.

Summary of findings

Accidents and incidents in the home had not always been reported to the local authorities and other relevant agencies.

Although risk assessments were in place, risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm.

Areas of the home were visibly dirty and the provider failed to protect people from the risk of infection or to maintain a clean environment.

Appropriate action was not always taken in timely manner when people's weights reduce; to ensure that their nutritional needs are met.

Effective systems were in place to enable the registered manager to assess, monitor and improve the quality and safety of the service. However, shortfalls had not been identified by the registered manager and actions had not been taken in a timely manner to improve the quality of the service.

Staff encouraged people to undertake activities. However, there were not enough resources to meet people's chosen activities. People were not provided with sufficient, meaningful activities to promote their wellbeing. Staff spent time engaging people in conversations, and spoke to them politely and respectfully.

The complaints procedure did not provide information about all of the external authorities people could talk to if they were unhappy about the service. People told us they would speak to the manager if they wished to complain.

One person's care plan did not correspond with the level of risk they had been assessed at. The home did not have all associated behavioural guidelines in place to identify and reduce risks. These risks involved when meeting people's needs such as behaviours that challenge, and details of how the risks could be reduced. Staff were unable to take immediate action to minimise or prevent harm to people based on specified guidelines.

Staff had received training relevant to their roles such as epilepsy, safeguarding, Deprivation of Liberty Safeguards (DOLS) and challenging behaviour. However, staff training were lacking in some other essential areas. Regular supervision and appraisals were lacking.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Staff meetings and residents meetings took place in the home.

Safe medicines management processes were in place and people received their medicines as prescribed.

During this inspection, we found breaches of regulations relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this report.

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?
The service was not safe.

The provider had not taken necessary steps to protect people from abuse.

There were not enough staff deployed to meet people's needs.

The home was not clean. Areas of the home were visibly dirty.

People received their medicines as prescribed and regular checks were undertaken to ensure safe medicines administration. However, medicines had not been properly managed and not all staff had been trained in medicine administration to enable them meet people's needs effectively.

Is the service effective?
The service was not effective.

Staff had not always ensured appropriate action was taken regarding weight loss.

Staff had not always received regular training in all areas considered essential for meeting the needs of people in a care environment safely and effectively.

People's human and legal rights were respected by staff. Staff had good knowledge of the Mental Capacity Act and the associated Deprivation of Liberty Safeguards, which they put into practice.

People had enough to eat and drink. Drinks were readily available throughout the day and people were offered a choice of hot and cold drinks at regular intervals.

Is the service responsive?
The service was not responsive.

People did not have access to diverse range of activities to meet their needs.

The complaints procedure did not contain all the information people needed.

Referrals were not always made to external professionals as required.

Is the service well-led?
The service was not well led.

The quality assurance system was not effective in rectifying shortfalls identified.

The registered manager was not aware of their responsibilities. They had not notified CQC about important events or the local authority of safeguarding incidents.

Staff told us that the registered manager was not approachable. Staff were not supported to work in a transparent and supportive culture.

Staff were clear about their roles and responsibilities.

Brightlands

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 13 October 2015 and was unannounced.

Our inspection team consisted of two inspectors and one expert-by-experience who spoke with people using the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had knowledge and understanding of people with learning disability and residential care homes.

This inspection was carried out to check if the provider had made improvements to the service since our inspection in February 2015. Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us about by law. We looked at safeguarding and whistleblowing information we had received.

During our inspection, our expert by experience spoke with nine people, inspectors spoke with three people and observed care and support in communal areas as some people were not able to verbally communicate their experiences. We also spoke with 12 support workers, two senior support workers, the registered manager, the operations manager and the maintenance man. We contacted other health and social care professionals who provided health and social care services to people. These included community nurses, doctors, speech and language therapist, local authority care managers and commissioners of services.

We observed people's care and support in communal areas throughout our visit, to help us to understand the experiences people had. We looked at the provider's records. These included four people's records, care plans, risk assessments and daily care records. We looked at a sample of audits the registered manager sent to us, satisfaction surveys, staff rotas, and policies and procedures.

Is the service safe?

Our findings

Prior to this inspection we received information of concern from members of the public in relation to care practices at the home. This included whistleblowing information not being investigated and poor staff practice. In addition, concerns had been raised about lack of consistency of records, incidents not being reported to the local authority and notifications had not been sent to the commission to tell us about incidents and accidents in the home.

Some people were not able to tell us about their views and experiences of living in the home. We observed that several people did not feel safe. They appeared frightened of one person who could present behaviour that people may find challenging. We observed one person run off when this person entered a room or came near them and they jumped up from the settee and ran down the corridor twice during our inspection, when they could hear the person approaching. Another person became anxious and said, "Luckily he didn't get me"; "Did he get you?" and "He had me before he won't get me again because (the manager) is there". This indicated that they had raised anxiety levels.

Staff had completed safeguarding adults training. Staff understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff had used this whistleblowing policy to report concerns and these had not always been acted on. The staff had access to the providers safeguarding policy which detailed that they should report safeguarding concerns to their manager. The safeguarding policy did not follow the local authorities safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The registered manager detailed to us during the inspection incidents that had happened that had not been reported to the local authority or the Care Quality Commission. Records of incidents in the home that we looked at confirmed this. The registered manager had not appropriately reported alleged safeguarding concerns, incidents and had not followed the local authorities' policy. This meant that effective procedures were not in place to keep people safe from abuse and mistreatment.

Accident and incident forms showed that staff had recorded and reported incidents where people had been challenging which had resulted in injury to others. There were some which were incidents between people but they had not been reported to social services. We observed an incident where one person pulled a staff member's hair on three occasions in an aggressive manner and displayed behaviours that challenged both staff and people who lived in the home. It was clear that the incident resulted in a person causing pain to the member of staff. The registered manager also confirmed to us that there was a similar incident the previous night. The same person had pulled another person's hair. We queried whether the incident on the 12 October 2015 had been reported to the local authorities safeguarding team. The registered manager said that "All reports are sent to my line manager who would advise if I need to report them". This created delays to the appropriate reporting of physical abuse of both staff and people to the local authority and CQC. This put people at continued risk of physical assault.

The examples above were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on 26 February 2015, we recommended that the service seek advice and guidance from a reputable source, about deploying adequate staffing to meet people's assessed needs.

At this inspection, we found the provider had not made improvements. There was not enough staff deployed to make sure that people were protected from harm or received the individual care they needed. We observed that one person had been signalling to staff that they needed assistance by banging the floor. Staff did not respond. This person then left their bedroom in an undignified manner to find someone to help them with their personal care. The person found our inspector and signalled they needed assistance. Other people had delays to their day as they left the service late to attend their chosen day service. The registered manager advised us that they were in the process of making changes to staffing rota's to enable staff to meet the needs of people better. Staff confirmed that the changes had been communicated to them during meetings and in a letter. The changes to the staff shift times were due

Is the service safe?

to start on 2 November 2015. This meant that since our last inspection on 26 February 2015, the provider had not effectively deployed staff to safely meet the needs of the people in the home.

The failure to adequately deploy staff to provide care and support to meet peoples assessed care needs was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was not clean. Areas of the home were visibly dirty. Bathrooms, shower rooms and toilets were dirty. Toilet seats and floors were stained and there was a strong odour of stale urine in several areas of the home. Some bins within the home were not suitable. To reduce the risk of infection, bins should be foot operated. We found several bins that were not foot operated. Staff purchased a new bin during the inspection to replace one that had broken. This was not foot operated. The kitchen floor was dirty, particularly around the cooker. There was a build-up of dirt, dust and hair on each stair of the staircase. The registered manager and staff told us that the home did not have a cleaner at present; staff were carrying out cleaning tasks as well as carrying out care tasks. One staff said, "Night staff do the cleaning but there is no check of what is done before they leave." The handy person was observed carrying out some cleaning tasks during the inspection. A new cleaner had been appointed the day before we inspected and the registered manager was in the process of carrying out recruitment checks to ensure this person was suitable to work in the home.

This failure to protect people from the risk of infection or to maintain a clean environment was a breach of Regulation 15 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we found that fluid thickener, which was used to thicken drinks to help people who have difficulty swallowing, was left in an unlocked cupboard in the kitchen. People had access to the kitchen. This thickening powder may cause people serious risk of harm. In February 2015 a patient safety alert was released detailing the dangers of ingesting thickener. As this prescribed thickener was not locked away out of people's reach, this meant that people were at risk of harm.

Night staff had not received medicines training which meant that if people needed 'As and when required' (PRN) medicines such as pain relief at night there was a delay with them receiving this. Staff confirmed with us that only senior support workers administer medicine and senior support workers did not do wake night shifts. If PRN is required for people, the night staff had to contact the person on 'on call', senior support worker or the registered manager to come out to give the medicine. We spoke to the registered manager about this and they told us that they had purchased training which senior staff and night staff would be expected to complete to reduce the length of time it takes to respond to people's needs. People did not always receive their medicines in a timely manner, to meet their needs. Medicines were not always kept safe and secure at all times.

The examples above showed that medicines had not been properly managed. This was a breach of Regulation 12 (1) (2) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people being given their medicines individually by staff. The medicines were dispensed from the medicines trolley and taken to people. They were given at the appropriate times and people were aware of what they were taking and why they were taking their medicines. Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had the capacity. Staff who administered medicines received regular training and yearly updates. Staff had a good understanding of the medicines systems in place. A policy was in place to guide staff from the point of ordering, administering, and disposal and we observed this was followed by the staff.

Daily checks were made of the medicines rooms to ensure the temperature did not exceed normal room temperatures. There was a system of regular audit checks of medication administration records and regular checks of stock. This was last carried out on 14 August 2015. This indicated that the registered manager had a governance system in place to ensure medicines were managed and handled safely.

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks and care needs, they detailed each person's abilities and current care needs. Risk assessments corresponded with each section of the care plan. For example, several people were at risk of choking. They had been assessed as medium risk,

Is the service safe?

so risk assessments were in place to show that they needed to have their food chopped into smaller pieces and needed prompts and reminders about slowing down when they ate.

Each person had been assessed to see what care and support they needed to evacuate the home in an emergency. A personal emergency evacuation plan (PEEP) was in place within the fire file. This file also contained guidance for staff and a map of the building. This meant that appropriate procedures were in place to keep people safe in an emergency.

Is the service effective?

Our findings

At our previous inspection on 26 February 2015, we identified one breach of regulations. Staff failed to adhere to professional's guidance on people's food intake. The provider submitted an action plan and said they would be compliant with the Regulations by 06 July 2015. At this inspection, we found the provider had made some improvements in this area. However, they remained in breach of the regulations.

Staff spent time encouraging people to eat and drink throughout our inspection. Staff were observed helping people to eat their lunch. The person who we observed was rushed and not given enough time to enjoy their meal at our last inspection was not rushed to eat their meal during this inspection. The person had been assessed by the speech and language therapist (SALT) and a recommendation was made that they keep their head in a neutral position to eat and drink. The staff who supported them followed SALT guidelines as required.

People had choices of food at each meal time and chose to have their meal in the dining room or their bedroom. People were offered more food if they wanted it. Hot and cold drinks were offered to people throughout the day to ensure they drank well to maintain their hydration. People were offered snacks such as biscuits during the day. We observed one person who needed lots of encouragement to eat; we saw that staff offered gentle prompts and reminders to eat their meal. People had been weighed monthly to monitor if they gained or lost weight. However, we found one person's weight had reduced by 10lbs and action had not been taken. We spoke with the team leader about this and they advised they would refer the person to an appropriate healthcare professional.

This failure to take appropriate action in a timely manner when people's weights reduce to ensure that their nutritional needs are met was a breach of Regulation 14 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received regular training in areas considered essential, by the provider, for meeting the needs of people in a care environment safely and effectively. Staff told us they had training specific to the needs of people who lived in the home such as autism and epilepsy. As some people could display behaviours that could be challenging, staff had received training in MAYBO, which is a physical intervention training course to keep people safe. However, there was no other specific behavioural training for staff to be able to identify triggers of behaviours that challenges which would have given staff skills to assess, prevent and manage such behaviour. Further, as people in the home had communication difficulties, there had not been any form of communication training to enable staff to effectively communicate with people. Our observations of staff communicating and people's communication passports evidenced that people needed support with communication.

Out of 33 staff, only 9 had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. We found no evidence that the provider had put plans in place for staff to achieve this qualification.

We looked at the records relating to training sent to us. We saw that staff had received both hands-on and e-learning training in a number of areas to assist them in their roles. Areas such as Safeguarding, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were done as e-learning. There was no evidence that members of staff had been assessed as competent in these areas after completion. A member of staff said, "E learning is done at home in my own time." This meant that while staff had received training in certain areas considered essential by the provider, they had not received training in other areas that were important in meeting people's needs effectively.

Staff told us that they had received supervision from their line manager. One staff said, "I have my supervision two months ago. We discussed issues in house, service users, staff and training." Another staff said, "Supervisions are done every 2-3 weeks". We looked at the supervision matrix given to us and found that out of 33 named staff, only four received supervision in September 2015. Four staff were off sick, one on maternity leave, two new staff and the remaining 22 members of staff had not received any form of supervision. We observed during our visit that there was no debriefing of staff after an incident. Working in a physical challenging environment such as Brightlands can be inherently stressful. Stress can be caused by events such as we witnessed regarding one person's aggression and

Is the service effective?

violence, which can have profound effects on staff. One strategy that can be effective in helping staff deal with such events is serious incident stress debriefing but, as we found out, this was not established at Brightlands. Following an incident we observed, the inspector had to debrief the staff in order to relieve the pain and evident stress caused by the person.

The failure to adequately train and assess staff to provide care and support to meet peoples assessed care needs and provision of appropriate support to staff is a breach of Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were procedures in place and guidance was clear in relation to Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. Staff were knowledgeable concerning the need to seek consent when providing care for people. Records evidenced that people's decisions were respected. For example, one person had declined to have their flu jab.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had good systems in place in relation to DoLS. Applications had been made to the local authority. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. People had been supported to attend dental appointments. Records evidenced that staff had also contacted speech and language teams (SALT) social services and relatives when necessary. People received effective, timely and responsive medical treatment when their health needs changed.

Is the service responsive?

Our findings

Some people had limited verbal communication and were not able to tell us about their experiences. We observed that staff were not always responsive to people's needs.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. Assessments were reviewed by the registered manager and staff, and care plans had been updated as people's needs changed. Staff used daily notes to record and monitor how people were from day to day and the care people received. The care plans were designed to meet each person's needs after their initial assessment. Where other agencies needed to be involved, this had been done and recorded. However, we found that one person clearly needed input from another healthcare professional to help with behaviours but was not referred.

People's care records were individualised and provided the reader with detailed information. This included information about the person, their care needs, communication skills, risks that they were exposed to in their daily lives, likes and dislikes, medication needs and goals for the future. The home operated a keyworker system where individual staff members were allocated to different people living at the home. A keyworker is someone who co-ordinates all aspects of a person's care in the home. These staff members held the responsibility for ensuring that the person they were keyworker for, received the most appropriate care for their needs and that their care records were up to date.

At our last inspection we found that that people did not have activities planned to meet their individual needs. During this inspection we found that this had not improved.

Care plans contained information about the kind of activities people were interested in. However, our observation showed that people were not able to take part in activities and leisure pursuits of their choice. They were unable to go out into the community for individualised activities as they wished. This was as a result of limited resources such as deployment of staff and home having one vehicle. Planned activities were displayed on the notice board for each person. However some of these activities did not take place. For example, in one person's care records, it stated that on Monday, they planned going out to the cinema and Thursday for swimming. This person's activities records showed that on Monday 05 October 2015, this person had personal care and breakfast in the morning and in the afternoon, looked at their book. On the Thursday, they did music books, building blocks and puzzles. This showed that the person had not gone to the cinema or swimming as planned. We asked the registered manager about this and they said that the activities were recently planned and some of them were being tried out. One person said to staff, "I want to go out to Dockside. I'm bored". Instead of going out, we observed staff gave the person a cookery book to look into to make a shopping list. These examples showed that people's choices of activities were not being achieved and the home was not always responsive to people's needs.

This failure to meet people's activities needs was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records and staff knowledge demonstrated the registered manager had identified individual behaviour that challenges others, and put actions in place to reduce the associated risks. Some people displayed behaviours that could impact on the wellbeing of others as well as their own health. The staff team worked closely with healthcare professionals to manage those behaviours to keep people and others safe. However, evidence of professional advice from the SALT team stipulating the need for an appropriate activity for two different people in terms of management of their behaviour had not been followed. For example, 25 March 2014, the registered manager made a referral to the local community learning disabilities team (CLDT). The referral was 'To get support with putting systems in place to manage routine to reduce behaviours.' On 01 May 2014, the CLDT made some suggestions to be implemented. We found no evidence of this in the person's records or in the home. We asked the registered manager about this. We were informed that they stopped following the suggestion made because it did not work with the person. We asked if they had made any referral back to the CLDT for further support and they said "No".

This failure to refer people for professionals support was a breach of Regulation 12 (1) (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager where the complaints policy was displayed as we couldn't find it. The registered manager took us to the small area between the front door

Is the service responsive?

and the front lounge and pointed to the notice board. The registered manager said, “It must have been removed”. He agreed it was not on the notice board. We looked at complaints procedure which was dated 11 November 2014. This stated that ‘The complaints procedure will be clearly displayed throughout the service and will be included in the service user guide’. The policy detailed that when a complaint was received the manager needed to meet with the complainant within two working days. The home manager then had a duty to investigate and seek resolution and provide feedback to the complainant within 14 days. Stage two of the complaints process was that complaint should be referred on to director of operations. Stage three of the process was to refer the complaint to the managing director. There was no stage four listed to identify what people should do if they are unhappy with the response from the provider organisation. For example, how to contact external agencies such as social services and local government ombudsman (LGO). We spoke with both the registered manager and the operations manager about our findings at the end of our inspection. The operations manager contacted us two days after our inspection and said that they had checked and would advise us that the complaints procedure that we saw during our inspection does in fact already have the contact details for the Local Government Ombudsman and the Care Quality Commission. This meant that complaints procedure that the service had within their policies and procedures file which staff had access to had missing information. The complaints procedure displayed did not have all the details required for people on how to clearly make a complaint.

This was a breach of Regulation 16 (2) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

Some people had limited verbal communication and were not able to tell us about their experiences. Staff commented about the registered manager and said, "I feel he is still learning. I feel he is quite a good manager. However, I don't think he is quite approachable. You need courage to go to his door"; "Management style is occasionally unfair, unsupportive. The manager is trying to put things in place. The team leader is approachable but the manager is not approachable" and "Some staff found him unapproachable. I do sometimes". Some staff told us that they would speak to the registered manager if they had any concerns.

The provider had a clear set of philosophies for the service. This stated 'Our goal at Clearwater Care is to give people the skills they need to lead rich and fulfilling lives'. Our observations and what we were told showed that these values had not been successfully implemented by the registered manager and staff who worked at the service. People were not always fully engaged and in suitable meaningful activities. The registered manager had not provided sufficient number of staff to enable people to live fulfilled lives with dignity and respect. These examples showed that the provider had not ensured and adhered to their stated values.

There were systems in place to review the quality of service that was provided for people. Regular audits were carried out to monitor areas such as infection control, health and safety, recruitment files, medication audit and medicines. However, the infection control audit carried out on 15 September 2015 had not identified the areas we had identified above. The registered manager carried out a service audit three times a year and this was last carried out in August 2015. The Group Operations Manager carried out the service audit on 01 September 2015. This looked at areas such as staffing, training, service users' issues, health & safety and COSHH amongst others. This audit identified areas for action such as the inability of frontline staff to administer medicine to people. It stated 'We need to ensure that there are sufficient staff on each shift to reduce risk for managers to have to come to the home out of hours'. Another example was that the same 'home visit record' identified behavioural issues we observed during our visit and it was agreed that a behavioural management plan be put in place. However, we found no behavioural management plan for the specific challenging behaviour we observed. These demonstrated that the regular auditing of the service did identify some of the issues identified at this inspection. However, it had not picked up on all of the issues such as incident reporting, training needs, staff support and appropriate staffing deployment. Actions identified by the operations manager had not been rectified when we visited.

Records relating to people's care and the management of the home were not consistent and can be confusing. Our own observations and the records we looked at did not always match. For example, in one person's care records we saw that they used a 'traffic light system' for behavioural risk. Red meant high risk, amber meant moderate risk and green meant low risk. It then rated 'personal safety injury to self, to others rated as green which meant low risk. Our observation and record we looked at indicated that this person posed a high risk to self and others. This meant that the care records did not correspond to the risks observed.

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records. This is a breach of Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager was not always aware of when notifications had to be sent to CQC. These notifications told us about any important events that had happened in the home. Notifications had not always been sent in to tell us about incidents that required a notification. For example, whistleblowing information received by the commission, which alleged neglect and emotional abuse of one person, was not notified to the commission. In other examples, records showed that there were incidents where people who used the service had physically abused staff and other people had taken place. CQC had not been notified. This demonstrated the registered manager did not understand their legal obligations.

This failure to notify CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Is the service well-led?

Communication within the home was facilitated through monthly team meetings. We looked at minutes of 05 October 2015 meeting. We saw that this provided a forum where areas such as risk assessments, upcoming new rota and people's needs updates amongst other areas were discussed. Staff told us there was good communication between staff team.

Monthly meetings were held with the people. These meetings gave people the opportunity to discuss any concerns they had or what they wished to receive whilst at the service. These meetings were often used to discuss the service's menu and the activities on offer, including any day trips they wished to take part in. We viewed the minutes from the last meeting held which had no date. We saw that this was used to discuss changes in menu, activities, goals and concerns and complaints.

There was a plan staff would use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed on the notice board. This was for emergencies outside of normal hours, or at weekends or bank holidays. A member of staff said, "I will call 'on call'. There is a list of who to call". This meant that there were suitable arrangements in place to provide support to staff when required.

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	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Failure to take appropriate action in a timely manner when people's weights reduce to ensure that their nutritional needs are met.** **Regulation 14 (1) (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **This failing to protect people from the risk of infection or to maintain a clean environment.** **Regulation 15 (1) (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Complaints procedure that the service had within their policies and procedures file which staff had access to had missing information. The complaints procedure had not been clearly displayed to detail to people how to make a complaint.** **Regulation 16 (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not notified CQC about important events such as, abuse and serious injuries.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18

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 9 HSCA (RA) Regulations 2014 Person-centred care This failure to meet people's activities needs. Regulation 9 (1) (a) (b) (c)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines had not been properly managed and failure to refer people for professionals support. Regulation 12 (1) (2) (b) (g) (I)

The enforcement action we took:
Warning Notice

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 manager had not appropriately reported alleged safeguarding concerns, incidents and had not followed the local authorities' policy. Regulation 13

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider has failed to operate an effective quality assurance system and failed to maintain accurate records.

Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The failure to adequately train and assess staff to provide care and support to meet peoples assessed care needs and provision of appropriate support to staff. Regulation 18 (2) (a) (b)

The enforcement action we took:
Warning Notice