Cephas Care Limited

Dunsland

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Dunsland is a residential care home that was providing personal care for up to 14 adults who have a learning disability or mental health need at the time of the inspection. At the time of our inspection 12 people were receiving a service. Accommodation was provided in an adapted building where each person had their own room and shared communal spaces.

The service was operating before the principles and values that underpin Registering the Right Support had been developed. However, the service would be expected to develop in line with these principles and other best practice guidance. Registering the Right Support ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 14 people. 12 people were using the service at the time of our inspection. This is larger than current best practice guidance. However. the size of the service having a negative impact on people was mitigated by the building continuing to resemble two semi-detached houses from the outside. Also there were no identifying signs, intercom or cameras, for example, outside to indicate it was a care home. Staff did not wear uniforms or name badges and mostly people were supported to access the local community in small groups, one to one with staff or independently.

People's experience of using this service:

The service was not well maintained, and systems designed to identify safety issues relating to the environment were not effective and placed people at risk.

Audits and quality assurance visits either did not identify serious issues with the building or recorded them and then did not take effective action to mitigate these risks. The environment was not suitable for some of the people living at the service and work was needed to ensure it was always clean and well maintained.

Complaints were poorly managed and not dealt with in line with the provider's own procedure.

Staff received the training they needed to carry out their roles but some further training was needed. This had already been acknowledged by the provider, who had started a new training programme.. There was no structured induction for new staff, although this was planned to be introduced. Staff were trained to administer medicines but some aspects of medicines management were not well managed. Health needs were mostly managed well but records were not always completed so we could not be assured of this.

Staffing levels fluctuated and the service had just taken on the responsibility for providing daytime occupation for people which was a challenge. This occasionally meant that people's opportunities to access the local community were affected or people were going out in groups which was not always appropriate. Those people who were more independent had good access to meaningful occupation and spent time within their local community and on following their own hobbies and interests at the service.

People told us they were happy at the service and were positive about the staff. Relationships were good and people were consulted about their care. Records did not demonstrate that people's capacity to consent to their care was always appropriately assessed and decisions taken in their best interests. People were supported to have choice and control of their lives but the service could not demonstrate that systems ensured support was always provided in people's best interests.

The new manager had begun to address some of the issues they inherited when they took over the service. Staff were in support of what the manager was trying to do. The provider did not have sufficient oversight of the serious issues at the service, despite regular quality audits and checks by senior management. Some key systems to identify and address issues were not fit for purpose. However, the provider promptly acknowledged this failing and took remedial action, which began on the day of the inspection visit. They continued to keep us updated with this.

We have made recommendations about the management of people's finances, the management of consent, procedures relating to end of life advanced care planning and about the need to seek out and act on feedback from relevant people.

The service aimed to apply the principles and values of Registering the Right Support. This aims to ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people using the service did not fully reflect the principles and values of Registering the Right Support for the following reasons: people were not fully included in decisions about their care and treatment and did not always receive care and support tailored to their individual needs.

Rating at last inspection: At the last inspection the service was rated Good (published 5 November 2016.)

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: We have identified breaches of regulation in relation to safety, premises, complaints and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up: We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

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. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Inadequate**

Dunsland

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors and a medicines inspector.

Service and service type:
Dunsland is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Dunsland is registered to provide accommodation and personal care to a maximum of 14 people. At the time of our inspection 12 people were living there.

There was no manager registered with the Care Quality Commission but the new manager intended to apply to become registered. Becoming registered means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This was an unannounced inspection.

What we did before the inspection:
Before the inspection we reviewed the information the provider sent us in the Provider Information Return (PIR). This is something providers send to us, at least annually, to give some key information about the service, what the service does well and improvements they plan to make. In recent weeks the provider has been sending a weekly update relating to certain aspects of the service. We reviewed this documentation as part of our planning. We also reviewed notifications which relate to significant events the service is required to tell us about. We used all of this information to plan our inspection.

During the inspection:
During the inspection we spoke with five people who used the service, a director of the business, the quality assurance manager, the older people's manager, the prospective registered manager, the maintenance member of staff and four care staff.

We reviewed five care plans, nine medication administration records and looked at three staff files which documented recruitment procedures and ongoing support for staff. We also reviewed rotas, staff training records and other documents relating to the safety and quality of the service.

After the inspection:
Following the inspection the provider held an emergency board meeting and set up an urgent action plan which they sent to us. Many actions were completed the day after our inspection visit. The plan was kept updated and we reviewed and considered this as part of our inspection process.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Some risk assessments were not detailed enough. For example, where an incident had occurred involving a hot drink, this had been assessed but the person still had free access to the kitchen and a kettle in their room. This placed other people at potential risk.

●Risks posed by the environment were not always assessed and not well managed when identified.

●We identified several trip hazards, including broken paving slabs outside the front door, items leaning against walls and portable radiator cables. One person's care plan stated that they had an increased risk of falling, 'When walking over uneven ground'. The risk from the broken paving slabs and uneven ground at the front of the service had not been considered in relation to this. Records relating to water temperature checks were not complete.

● We noted uncovered radiators, exposed pipes and an unrestricted window in an unused room which had a protruding sharp object. Risks posed by these had not fully been considered in relation to people's epilepsy, poor mobility, increasing age and mental and physical health.

●Where risks were assessed we did not always see that adequate measures were put in place. For example, one risk assessment identified that fire doors, which closed in response to loud noise such as the fire alarm, were too sensitive and sometimes closed due to other noises. This had resulted in one person sustaining a fall but we could not see that sufficient control measures had been put in place to reduce the likelihood of a further incident. It was noted that some fire doors were not closing properly but effective action was not taken to mitigate this risk. A rear wiper on the service vehicle had been identified as being faulty in January 2019 but had not been repaired for many months despite staff continuing to record the fault.

Systems designed to monitor the safety of the environment were not robust and a failure to act promptly on known risks placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following our inspection the provider gave us assurances that all uncovered radiators had been turned to their lowest setting and covers were being sourced. They also told us they had fully addressed the issues with the unsafe paving slabs, other trip hazards and fire doors the day after our inspection.

●Other risk assessments relating to people's care and support were in place and reviewed in care plans.

Using medicines safely

●There was a system in place for ordering and giving people their medicines as prescribed. However, the system did not always ensure medicines were given safely. Medicines were stored securely and their administration was recorded on Medicine Administration Records (MAR charts). Regular checks were in place to check the accuracy of these records, however, we identified a discrepancy where the records showed a person was recently given more of a medicine than intended by the prescriber.
●There was no effective system in place to report incidents and investigate errors relating to medicines.
●There was insufficient written guidance about how people preferred to have their medicines or to help staff give medicines prescribed on a when required basis appropriately and consistently. Records of people's currently prescribed medicines were sometimes inaccurate and potentially misleading which could have led to error.
●Medicines such as creams and emollients were sometimes not handled in a way that ensured they would not be used after their shortened shelf-life on opening. There was a lack of instructions for staff showing where on people's bodies these medicines should be applied.
●Medicines were being stored at temperatures above the upper limits of the accepted temperature range. In addition, we noted that a medicine requiring refrigeration was being stored at room temperatures and so may no longer have been safe for use.
●Staff were trained and assessed for their competency to handle and give people their medicines safely, however, staff had not recently been assessed for giving a person their medicines by a specialist technique via a tube through their skin (PEG). There were gaps in the care records relating to essential activities needed for this technique to be safe.

Whilst there was a generic system in place for ordering, recording and administering medicines it did not ensure people always received their medicines as prescribed. This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider ensured staff received training in safeguarding people from abuse. Staff understood how to report concerns and knew how to spot the signs that might indicate someone was being abused
●The provider took appropriate action if they suspected a person might be at risk of abuse. Safeguarding matters had been appropriately reported to the local authority safeguarding team and notified to CQC.
● Systems were in place to safeguard people from financial abuse where the service helped people manage their money. There was a series of checks and balances in place to ensure people's money tins were well managed, and we checked balances for two people. They were correct and receipts were well organised. However, we found that additional monies were held offsite for people, at another of the provider's services, and the keys kept there. This meant people did not have instant access to all of their money and we could not audit these amounts.

We recommend that the service ensures best practice procedures are followed to ensure people have better access to and oversight of their finances.

Staffing and recruitment
● Staff told us there were enough staff to provide care and support within the service but three people said that staff shortages had sometimes meant that people's opportunities to go out had sometimes been limited. One staff member said, "Sometimes [we] can't get agency which impacts on people's day and means other people can't go out."
●Recent changes to people's funding meant that people no longer attended their routine daytime activities outside the service and the staff were expected to provide leisure opportunities for people. We noted that people went out for lunch as a group on the day of our inspection. This was despite the fact that one

person's care plan clearly identified that they did not like to eat with other people.
●Although staff told us that supporting people's leisure time was a challenge for the service, care plans and daily records showed people were being given access to the community whilst funding arrangements were still being confirmed.
● Staff were recruited safely and appropriate checks on their character and experience were undertaken before they took up their post.

Preventing and controlling infection
● There were systems in place to reduce the risk and spread of infection. Most staff had received infection control training, however six staff either had no record of completing this training or were overdue for a refresher, according to the provider's own schedule. Equipment, such as aprons and gloves, was available for staff.
● The service was mostly clean but we did identify areas which would benefit from closer attention. For example, dirty wheelchairs and some bathrooms required a deep clean. There was no structured programme for cleaning, with staff telling us they did it when they could fit it in.

Learning lessons when things go wrong
● The registered manager had recognised that improvements were needed in documentation across the service and was implementing new care plans.
● The provider demonstrated a positive response to our feedback given during and after this inspection. They took some immediate action in terms of the safety of the environment and sent an action plan outlining what they planned to do to address the other serious concerns which meant the service was not safe. The provider accepted our findings, took steps to analyse how systems had failed and put some immediate steps in place which were designed to protect people.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant that the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

●There was limited signage throughout the building and the noticeboard in the dining area contained information for staff, such as advice on whistleblowing, which might have been more appropriate in a staff room or office.

● Much of the service was not suitable for the needs of the people living there. Access was uneven and the front steps were not ramped even though some people had difficulties with their mobility and used a wheelchair to go out. One person struggled to go upstairs and there was no lift. Another told us they couldn't access the shower as there was nothing to hold on to. A new kitchen was due to be fitted but staff told us no particular adaptations, such as an adaptable height worktop, had been included to help as many people as possible take part in mealtime activities.

●The building was two houses joined together and there were two staircases and some small and narrow corridors. The layout of the building meant it would be difficult for staff to have an awareness of where everybody was. The front door had no alarm or internal lock and staff would not necessarily be alerted if somebody, who might be at risk in the community, were to leave the building.

●We observed places where skirting boards were damaged and where there were some holes in the floor and walls. Fire doors had been drilled through to place additional locks. This left holes which meant they would not be effective in the event of a fire.

●A significant programme of refurbishment is needed to raise some areas of the service to the required standard. The provider has assured us that this is planned but we saw evidence that audits had been identifying this need for several months without it being fully addressed.

The security and safety of the building had not been fully considered for the people who lived there.This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People's rooms were individually decorated and the service had lots of people's artwork and photographs displayed

Ensuring consent to care and treatment in line with law and guidance

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● We found that there had been appropriate applications for DoLS and one authorisation was still pending. Staff had received training in MCA and DoLS but would benefit from a more in depth understanding.
●Issues relating to consent required further review, especially for anyone with a diagnosis of dementia. We found that some parts of people's care plans had been explained to them and signed by them to document this, but this was not always the case.
●For those people who may not have been able to consent to aspects of their care we did not always find that their capacity to understand the decision had been assessed and an appropriate Best Interests meeting put in place. This was the case for some medical procedures such as flu vaccinations and for the provision of a catheter, although other healthcare decisions were appropriately taken and well documented. We found no impact with regard to the provision of a catheter or of vaccinations but decisions such as these require to be taken according to a structured process.

We recommend that the service reviews their procedures regarding the establishing and recording of people's consent to care and treatment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before any service was provided, this was to ensure their needs could be met by the service. Many people had been at the service a number of years and the original assessment of their needs was quite historic but we saw that regular reviews were held to make sure people's current needs were identified.
● Care records contained information relating to a variety of needs including people's medical history, personal care, medicines, mobility, eating and drinking, and communication. However, some did not contain sufficient detail to ensure person centred care was always delivered by staff.

Staff support: induction, training, skills and experience
●Two staff records we viewed, including one for someone recently employed, did not document a structured induction and a staff member, new to care, confirmed they had not had one. However, we saw that staff had received appropriate training and shadowing experience before they began working as a full member of the team.
●Staff demonstrated some good skills, but we noted further improvements were needed when supporting people when they became distressed and agitated. Strategies to manage people's behaviour at these times required reviewing to minimise incidents and ensure other people were not negatively affected by it.
●The new manager had identified, along with the provider and staff, that additional training was required to ensure staff had all the skills they needed. On the day of our inspection some specialised training was being delivered by an external provider. We noted a commitment to improve training and a new structured induction booklet had been devised but was not yet in operation.

Supporting people to eat and drink enough to maintain a balanced diet
●People's needs and preferences relating to eating and drinking were recorded in their care plans. Staff demonstrated good knowledge about people's needs in this area. A pictorial menu board showed people the menu choices for each day. People were involved in choosing their meals and making their own drinks and simple meals.
●People received a balanced diet and were positive about the food. One person who used the service grew

their own salad crops and told us they enjoyed eating them.

●People's weights were monitored, although some records were not current. One person was recorded as losing weight, possibly due to their health condition but no weight had been recorded since February 2019. Although the person was not underweight in February their care plan said that a referral to a dietician should be considered if they continued to lose weight. We could not be assured that the service had good oversight of their current nutritional needs.

● Another person's care plan documented specific needs and risks around their eating and drinking and staff demonstrated good understanding of these. Staff were trained to administer food and medicines via percutaneous enteral gastronomy (PEG) for another person and received support from district nurses in carrying out this task. PEG is where food and medicines are introduced directly to the stomach and is used where people have swallowing difficulties, for example. However, records showed that staff competency to carry out this task had not been assessed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

●People were supported with their health needs. Some people's records demonstrated that their healthcare needs were responded to promptly and their health was well monitored. Sometimes records were incomplete which made it difficult to be assured that people's needs had been met. For example, one chart for recording a person's bowel movements had not been completed for seven days. The person was not unwell and so we concluded this to be an issue of poor record keeping. This incomplete recording meant staff had poor oversight of this person's health.

● If someone needed to go to hospital a system was in place to ensure all of the relevant information would be sent with them to help ensure consistent care.

●Where people needed additional support from healthcare professionals such as the falls team, or dietician we saw that this was arranged promptly, although in one case there was a delay.

● We saw evidence of partnership working with district nurses, dieticians, dementia specialists and other healthcare support services. Recent reviews of people's needs had taken place with local authority colleagues and the service had operated as effective advocates to try to ensure people could continue with meaningful daytime occupation.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were kind and caring and we observed that relationships were good. People told us they did not like it when staff left and there had been some recent staff changes which had been difficult for them. Staff were sensitive to this and told us how they helped people manage their anxiety over new staff and new routines.
- Staff mostly demonstrated positive interactions with people and were courteous and patient. We saw staff members taking ten minutes to calm one person who became very tearful.
- We observed less skilled interactions supporting people's anxiety, distress and associated behaviours. Language used was inappropriate at times, although not unkind.
- Strategies to manage issues of distress and anxiety were not clear or were not always appropriate. For example, one staff member told us staff responded to one person's behaviour by telling them they were being 'naughty'. A sanction would then sometimes be imposed to deprive them of an activity on the following day. This was ineffective as the person did not understand cause and effect and resulted in an escalation of distress the following day. We noted, however, that on the day of our inspection some training was delivered which aimed to give staff more insight into managing people's behaviours successfully without escalating them.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to play an active role in the day to day running of the service as much as they were able and wanted to. People were consulted about their care plans and matters affecting them were discussed and recorded in most cases. We saw that one person's plan documented that during care plan review meetings they needed an advocate. However, one had not been provided for a recent meeting and the record stated 'Discussed with [person]'.

Respecting and promoting people's privacy, dignity and independence

- People chose their own clothes and told us they helped to do their own washing if they could.
- Staff encouraged people to be independent. One person told us, "I do my own laundry and chores. I keep my bedroom tidy."
- Records confirmed that there was a commitment to increasing people's independence and making sure people did not become deskilled due to increasing age or health conditions.
- People confirmed that staff were mindful of their dignity when giving personal care and care plans recorded if people were happy to receive this kind of care from both male and female members of staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

End of life care and support

● The service had not developed their practice in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life.

● Most care plans contained a section in relating to people's end of life care wishes and needs. However, two of these were blank and one was not present in the records we viewed. Although the client group at the service was not approaching this stage of life, advanced care planning, especially for those people without immediate families, was required.

We recommend that the service reviews best practice guidance for end of life care, and where appropriate, discusses end of life preferences with people or their representatives.

Improving care quality in response to complaints or concerns

●The service had a complaints policy and procedure in place. We reviewed the complaints folder and found a complaint dated 27 April 2019. This complaint regarded the unsafe paving slabs at the front of the service and clearly highlighted a risk to life. It was clear from the body of the complaint that the issues had been raised, possibly informally on previous occasions and had been recorded in the maintenance book. No action had been taken in response to the complaint and the person's complaint had not been acknowledged.

● The manager told us that the complaint must have been pushed under the door and then filed away. They had no memory of it. This response was not in line with the provider's own complaints procedure and overlooking a complaint of this nature continued to place people at risk.

The provider was not implementing and following their own procedures for managing and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●People's care records documented their needs and preferences and staff demonstrated a good understanding of these. Records were person centred, regularly reviewed and covered a wide variety of needs. It was clear that people had been given the opportunity to set future goals for themselves either on a small or large scale and these were revisited during reviews.

●Sometimes plans were not sufficiently detailed to ensure staff, especially new staff, would have all the information they needed to guide them. Some information was not clear as old information had not been

archived. The provider was planning a new care plan system and all documentation was in the process of being reviewed.

●People had the opportunity to access the local community and take part in a variety of local activities. One person told us that they had a bus pass and enjoyed using public transport around the local area.

●Recent changes to funding had meant that some of these opportunities had been changed recently and the service was planning to provide more activities themselves. On the day of our inspection people were occupied doing some arts and crafts, knitting, going out for lunch and one person told us how they grew their own vegetables from seed. Staff told us that in recent weeks people had needed to be in the service more as new arrangements were not in place and this had impacted negatively on some people who were unhappy about this.

●Resident meetings were not held but staff told us that the communal element to these meetings did not work well. Instead people were given the opportunity to chat through any issues they had but this was not recorded.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

●Quality assurance systems, although comprehensive, were not effective in driving improvement. The monthly provider visits had either not identified some of the serious health and safety issues we found or had identified them, such as the broken paving slabs, and continued to note them each month without resolving the issue. Clear oversight of risk at the service was poor.

● Some systems were not fit for purpose. Systems to report maintenance issues were not robust and serious issues, continually flagged up by staff in accordance with the provider's own procedures, were not acted on. This placed people at risk of harm. Induction of new staff required more structure to ensure new staff felt fully supported in their roles. Systems to manage and respond to complaints were not robust.

The provider had failed to establish effective systems to assess, monitor and mitigate risk or to seek and act on feedback from relevant stakeholders. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The new manager had been in post for approximately 12 weeks and told us, "A lot was not in place. I came into a blank canvas." They had begun to draw up action plans and update the service's ongoing improvement plan. The task was very large and, since the inspection visit, the provider has given us assurances that they will support the new manager and monitor the management of the service more closely.

●There was recognition on the part of the management, regional management and senior staff at the organisation, that some matters needed urgent attention. The provider was honest and open and anticipated our potential response following the inspection visit. They were proactive and took immediate action to address the safety issues and restructured the way maintenance issues were managed, making some key staff changes. However, we would have expected the provider to have identified the serious shortfalls at the service for themselves, rather than acting in response to our findings.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●Staff and other stakeholders had not been contacted, via a survey or questionnaire for example, to give their views on the service and make suggestions about the running of the service. Resident and relatives meetings were not held, although there was some contact with relatives during care plan reviews and informally during visits.

We recommend that the provider develops an effective system to gather feedback from people who use the service and other stakeholders, in order to help develop and improve the service.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

● Staff were clear about the expectation of their roles and, following a recent period of significant change in leadership at the service, were broadly positive about the new manager. Staff told us that morale was improving and they were keen to help drive the service forward. We found staff to be committed and focussed on the needs of the people who used the service. They had opportunities to provide feedback at staff meetings but some continued to feel unsupported at times, although they acknowledged that supervisions had improved since the new manager started.
●The manager had not yet registered with CQC but was intending to do so and had an understanding of the role and the regulatory responsibilities it carries. Notifications, for incidents which the service is required to tell us about by law, had been appropriately submitted.

Working in partnership with others
●The service worked in partnership and collaboration with other key organisations to help deliver consistent care to people. Staff documented advice and guidance given by other professionals and records showed they worked in accordance with it.
●There was a link with another of the provider's services locally and it was hoped that this could be further developed to benefit both residents and staff.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that all risks to the health and safety of the people who used the service were assessed and mitigated. The provider also failed to ensure the proper and safe management of medicines. Regulation 12 (1), (2) (a) (b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to operate an effective system to identify, receive, record, and respond to complaints. Regulation 16 (1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service or to mitigate identified risks. Regulation 17 (1) ,(2) (a) and (b).