Care Quality Commission

Richmond Psychosocial Foundation International

Lancaster Lodge

Inspection report

21 Lancaster Park
Richmond
Surrey
TW10 6AB

Tel: 02089401052
Website: www.rpfi.org

Date of inspection visit:
01 March 2016
02 March 2016
03 March 2016
08 March 2016

Date of publication:
01 June 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 1, 2, 3 and 8 March 2016.

Lancaster Lodge is a care home for up to 11 adults with mental health needs.

The home did not have a registered manager. The previous manager left on 18 January 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

In September 2015, our inspection found that the service met the regulations we inspected against, received an overall good rating and a good rating for each of the five key questions.

A number of changes to the service had taken place between the last inspection and this inspection. This included a change to the way therapeutic support was delivered. The longstanding manager and experienced staff had also left the service. People told us staff tried hard to provide a supportive service. This was often not achieved as many of the staff was new and therefore relationships and trust had not been built up.

People said that since the previous manager and some more experienced staff had left this made it more difficult to have their needs met and support provided in the way they wished. They told us this problem was made worse as more experienced staff had also been on leave or on training away from the home. This was at a crucial time when many changes were being made to the way that support was being delivered.

People told us that they were not given the opportunity to choose the way that their individual and group activities would be delivered. Rather they were presented with a new method of service delivery that concentrated on therapy being delivered in-house, by staff rather than by external psychotherapists whom they had built up bonds and relationships with. This set back their development of the life skills required to live independently, further their education and gain employment. They said that staff no longer provided the support they required in a way that suited people using the service.

Key documents were missing and records not kept up to date. The support plans for people using the service were missing, incomplete or did not contain up to date and regularly reviewed information. This meant staff were not able to perform their duties efficiently.

The new staff were not knowledgeable about the people they worked with. They had inappropriate experience and qualifications. In spite of their best efforts and hard work to provide care in a supportive and friendly way, they did not have appropriate experience and qualifications to. This was not successful beyond meeting daily basic needs. Staff had received induction training that did not provide them with the skills and knowledge to deal with the complex needs of people using the service and were reliant on shadowing more

experienced staff who were often not available. As part of their induction training, staff had not received training in behaviour that may challenge, de-escalation techniques or mental health. This meant that they were not appropriately skilled to deal with potentially challenging and stressful situations for people as well as themselves.

As support plans and risks assessments were not up to date potentially people were not protected from taking unacceptable risks, including those associated with nutrition and hydration. More experienced staff, who knew people well were able to support and advise them regarding healthy and balanced diet options.

People and their relatives said that they did not feel listened to or find the management team at the home or within the organisation, approachable or responsive. Neither did they feel encouraged to provide feedback. There was little recorded evidence of the service being monitored or quality assessments taking place.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. This was in relation to medicine being incorrectly administered and not being accurately recorded. There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. People were not safeguarded from abuse and improper treatment. Risks to the health and safety of people were not assessed. Reasonable steps were not taken to mitigate risks. Staff had not received appropriate training, support or supervision. Peoples' care and treatment did not enable and support relevant people to understand the care or treatment choices or to discuss them with a competent health care professional. This included the balance of risks and benefits involved in any particular course of treatment. The care and treatment did not meet peoples' nutritional and hydration needs, regarding their well-being. People did not have their needs met and their preferences were not considered. The home failed to operate a quality assurance system. The management team did not have suitable qualifications or experience of working directly with this client group. Required notifications were not made to the Care Quality Commission. We are taking action against the provider for their failures to meet regulations, according to our enforcement procedures. We will report on this when our action is completed. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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?

Inadequate

The service was not safe.

People said that they did not feel safe and there were no up to date risk assessments on file. The home did not raise safeguarding alerts consistently and new staff had not been trained in de-escalation procedures. There were insufficient numbers of suitably qualified or experienced staff to keep people safe. Staff were Disclosure and Barring Services (DBS) security checked as part of the recruitment process.

Medicine was not safely administered, or medicine records correctly completed, monitored or regularly audited.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had been adequately trained or supported to meet people's needs. People's needs were not effectively met and agreed with them. Not everyone had a support plan. The support plans that were in place were not up to date, meaning people's food and fluid intake was not monitored, although staff encouraged people to have balanced and nutritious diets.

There were no mental capacity assessments, outcomes decisions or Deprivation of Liberty Safeguards (DoLS) in place. New staff had not received training in the Mental Capacity Act 2005. This meant people's rights were not protected.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt that staff tried hard to meet their needs on a daily basis. They did not feel valued or respected by the management, organisation and were not involved in planning and decision making about their care. People's preferences for the way in which they were supported were not suitably met or clearly recorded.

Care was centred on people's immediate individual needs, in a

re-active and unplanned way. New staff and the management were not familiar with people's background, interests, personal preferences well and needs. Staff provided support, care and encouragement as best they could in a chaotic environment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples' recreational and educational activities were greatly reduced by the lack of organisation, support and record keeping. Two peoples' support plans were missing and the information for thee others was out of date. Activities only continued due to the knowledge of the few experienced staff still in post. The daily notes did not contain information that would inform staff coming on duty of what to expect. Regular care reviews were not taking place or being recorded.

People and relatives told us that any concerns raised were either not discussed and addressed or not done so as a matter of urgency.

Is the service well-led?

Inadequate

The service was not well-led.

The home had a negative culture that was not focussed on people or their individual needs. People were not familiar with the management structure or who was responsible for running aspects of the service. The management and its structure did not enable people to make decisions by encouraging an inclusive atmosphere.

Staff were poorly supported and the training provided did not equip them to meet people's needs.

There were no discernible quality assurance, feedback and recording systems in place for the service to monitor standards or drive improvement.

CareQuality Commission

Lancaster Lodge

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 was an unannounced inspection and took place on 1, 2, 3 and 8 March 2016. It was in response to whistle-blowing concerns raised through the Care Quality Commission website.

This inspection was carried out by one inspector.

There were six people living at the home, one of whom was in hospital. We spoke with five people using the service, five staff, three relatives, two former staff members, the former registered manager, acting interim manager, service commissioners, the local authority quality assurance and safeguarding teams, the St George's Community Mental Health Team and the nominated individual.

Before the inspection, we considered notifications made to us by the provider, whistle-blowing concerns raised and information we held on our database about the service and provider. We also considered concerns and complaints raised from a number of sources including relatives and care professionals.

During our visit we observed care and support provided, looked around the home and checked records, policies and procedures. These included the staff recruitment, training and supervision systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for three people using the service, who had them. The two other people did not have care plans in place.

Inadequate

Is the service safe?

Our findings

People said they no longer felt safe living at the service. One person said, "The way they have treated us is disgusting, I don't feel safe with them (management team) in the house." Another person told us, "(person using the service) was manic and we had to stay in each other's rooms to stay safe." A relative said, "I had to attend to (Person using the service) myself on three separate occasions, two of which were spent overnight as a one-to-one, as they refused to give her this service." A staff member said, "A lot of the staff are new and thrown in at the deep end."

People using the service and staff told us of errors in medicines administration and recording. One person said, "I have been given tablets when I am supposed to have a break from them and I have been given someone else's medicine." Another person told us, "One week staff couldn't dispense medicine and (a more experienced staff member) had to come in. The agency staff had mixed up our tablets; fortunately we know our needs and were able to say it was wrong."

The medicine file had a front sheet that recorded specimen signatures and initials of staff that had responsibility for administering medicine. These sheets contained specimen signatures and initials of staff that had left and did not include those of all new staff. Because of this it was unclear who had administered medicines in the service and if they had been trained to do so.

A person using the service was prescribed a double dose of Fluvoxamine medicine for one week. This was a labelling error by the pharmacy. The error was not picked up, by the home as there was no monitoring check recorded and the last tablet count took place in December 2015. There was no record of the same person receiving some of their medicine for 3 days in February 2016. The hand written instructions on the Medicine Administration Records (MAR), for this medicine stated 'take in a 21 week cycle, then seven day break'. The medicine was to help them control their mood swings. Medicine was stored in a locked facility. The staff told us they had received medicine training although new staff were still apprehensive about taking responsibility for medicine administration. No controlled drugs were kept on the premises.

The incorrect administration of medicines and the errors in record keeping of medicines administered constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

There were four new staff members and four experienced staff employed by the provider to work at the home. Of the four experienced staff, one was away on two weeks training and another had recently returned from annual leave. In their absence the shifts were covered by agency workers who were not familiar with people using the service. On some shifts, new and inexperienced staff were paired with agency staff, meaning that they were the senior on duty. The nominated individual changed the staff rota, during the inspection so that there was a more experienced staff member always on duty with agency or new staff. They did this by drafting staff in from other home's within the organisation who were not familiar with the type of service or people using it. This had a negative impact on the support people received.

During the second day of our visit, one person became very distressed and the permanent staff member, worked really hard to reduce the person's distress, although was clearly struggling to cope. They were the senior on duty with an agency staff member and had been in post seven weeks. They telephoned for advice and the nominated individual arrived to lend support, but this was after the situation had calmed down. The impact on people using the service was that they were not receiving care and support in a safe environment.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. This constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

Failure to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

When we visited, the more experienced staff were aware of how to raise a safeguarding alert and had received safeguarding training. The new staff were unaware of the process to follow to raise a safeguarding alert. During the second day of the inspection, there was a visit by the local community mental health team in response to two safeguarding's that had been raised. The safeguarding alerts had been raised by a friend of a person living at the home. The home had not raised safeguarding alerts, although one of them referred to errors in medicine administration. The interim manager and nominated individual were unclear of the circumstances under which a safeguarding alert should be raised, who was responsible for doing so and to whom.

People were not safeguarded from abuse and improper treatment. This constitutes a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

One person's file contained a risk assessment that was not dated and did not record who had carried out the risk assessment and in what capacity. Another person had a care plan with a risk assessment dated 26 October 2016. The other three files did not contain any risk assessments. This meant that the three care and treatment plans that were in place were not underpinned by risk assessments to promote people's safety. The home produced risk assessments for two people who went to hospital under section during the inspection. The assessments were carried out in the hospital environment. They identified that the two people's needs could not be met, by the home and their placements were terminated. The assessments were dated, but did not state who carried them out, in what capacity and if they were authorised to do so. The assessments were two pages in length and contained limited information. During the inspection process, the nominated individual enquired if the Care Quality Commission had templates to carry out these assessments. This indicated that the home did not have an assessment process of its own.

The staff said they shared information regarding risks to individuals including any behavioural issues during shift handovers and if they occurred. No written handover information could be located by the interim manager or nominated individual. There were daily notes for each person. These were prescriptive of a person's day and did not inform staff coming on shift of what to expect.

Failure to assess the risks to the health and safety of service users receiving the care or treatment and mitigate any such risks constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve

the problems we found.

Failure to do all that is reasonably practicable to mitigate any such risks constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

The home's accident and incident file contained information regarding three circumstances that led to people having to go to hospital under section of the Mental Health Act 1983 and action taken by staff. The quality of the recording made it difficult to understand and to, determine what had taken place and the action pursued by staff. The information was unclear, reports were differently formatted, incomplete, not signed and in one case reference was made to the Residential Care Homes Regulations, 1984 in the guidance to follow. These regulations are no longer in use. Two further instances of people being admitted to hospital under section, took place after our last visit to the home.

There was a whistle-blowing procedure but staff said they had little confidence in it. One member of staff agreed to talk to us, although they insisted we talked away from the office and took a stealthy route to a room, using the back stairs so that other people did not know they were talking to us.

The provider's staff recruitment procedure recorded all stages of the process. This included advertising the post, providing a job description, person specification and being short-listed for interview. There was a formal interview that contained scenario based questions to identify people's communication skills and knowledge of the field in which the service operated.

A new staff recruitment file contained only one reference application whereas the organisation's procedure required two. The nominated individual said that the second reference application was 'probably sent by e-mail', but no evidence of this was produced during the inspection process. In the files we looked at, the successful applicants had little direct experience of working in this field that meant they would require intensive support and supervision, whilst gaining experience. They shadowed experienced staff for one week, prior to taking on responsibility for their roles, if experienced staff were available. One staff member told us that they had not received a formal induction.

The responsible individual said that they were recruiting a senior support worker and a support worker level 3 in Health and Social Care or above, in the short-term and the organisation would recruit a registered manager in the longer term. Disclosure and Barring (DBS) checks were carried out prior to starting in post. The home had disciplinary policies and procedures that were contained in the staff handbook.

Inadequate

Is the service effective?

Our findings

People told us they felt that staff tried to help them to do the things they enjoyed and wanted to do with their lives, although this was problematic. This was because many staff were new, not familiar with people who used the service and bonds of trust had not been built up in the same way they had with more experienced staff.

Three people said they could not understand why more experienced staff were directed to attend two week training courses, away from the home, when it was in a period of transition and new staff needed their support and guidance. One person said, "Why change everything all at once, when as vulnerable adults we can't deal with change well? There is no point in taking senior staff off for training, when everything is changing." Two people who use the service separately told us of a situation where they had to restrain another person using the service as staff did not know what to do.

The responsible individual identified the need to introduce restraint and de-escalation training as part of an action plan they had put together during the inspection process. One person said, "I had to restrain (Person living at the home) because she was in psychosis and staff did not know what to do. It feels like we are the staff." Another person told us that during this episode, they had to phone a former member of staff to explain to staff what they needed to do. This was confirmed by the former staff member. Another person said, "This house has been chaotic and it is not the fault of the staff, it's the management. It's disorganised and stressful for residents" During our visit staff tried hard to meet people's needs with differing levels of success. This was dependant on their previous training, experience and knowledge of people using the service, with more experienced staff able to deal better with challenging situations and diffusing them.

Staff told us and records stated that they had received induction training, although one staff member said they had not received induction training. There were induction procedure and expectations documents for new staff. The induction training was minimal. It included safeguarding, medicine, fire procedure and Deprivation of Liberty Safeguards (DoLS), with little information about or focus on the individual people using the service, mental health training or how peoples' mental health needs should be met.

New staff relied heavily on shadowing more experienced staff to get to know people and their preferences in how care and support was delivered. Many senior staff had left, were on training or on leave. This meant new staff could only spend time shadowing experienced staff, if they were available and made it more difficult to build up relationships with people through a gradual process. Previous induction training had included all aspects of the service and people who use it.

The home had a restraint policy and procedure. More experienced staff had received training regarding challenging behaviour, restraint and de-escalation techniques. However new staff had not received training in restraint or de-escalation techniques, as this was not included in the induction. When asked what they would do in a challenging situation, a staff member replied, "I would use my common sense." The staff member was confronted with a challenging situation, after this conversation and responded by calling the police to intervene to keep the person safe.

Staff confirmed that information was verbally given to staff coming on duty at shift handover. New members of staff were unaware that this information had to be written up as the more experienced staff had been on leave or training. The last records for day shift handovers were 14 December 2015 and night shift 24 February 2015. The records we saw did not demonstrate that regular staff supervision, weekly staff meetings and annual appraisals took place. The inspector requested information that included records of staff supervision. The record contained dates for staff operational and clinical supervision that were after the inspection visit dates. There was no pre-inspection supervision evidence provided.

Staff did not receive appropriate training, support or supervision. This constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) required the provider to submit applications to a 'Supervisory body' for authority. Staff received mandatory training in The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). At the previous inspection there was documentation that verified all people using the service were assessed for capacity, by trained staff, in their individual support plans. At this inspection this documentation was not in place. Senior staff were aware of the Mental Capacity Act principles. We did not ask junior staff.

The care and treatment of service users was not appropriate and did not enable and support relevant persons to make, or participate in making, decisions
relating to the service user's care or treatment to the maximum extent possible. This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

The care and treatment of service users did not enable and support relevant people to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

The support plan information recorded pertaining to people's health needs, including nutrition or hydration was not monitored or up to date. There were no nutritional assessments or where appropriate weight charts. This meant that peoples' nutrition and hydration needs may not be met. Each person had a GP and staff said that any concerns were raised and discussed with the person's GP as appropriate. Staff encouraged people to follow a healthy diet, during the inspection. People told us they enjoyed the meals provided. A person using the service said, "I enjoy cooking, I find it therapeutic." Cooking responsibilities were rotated on a daily basis with each person taking responsibility for a specific day with whatever level of support required from staff. People using the service were also responsible for being involved in the home's on-line food shopping, organising a menu plan and daily tasks such as buying milk and bread. The home

had a vegetable plot that produced home grown produce.

The care and treatment did not meet peoples' nutritional and hydration needs, having regard to their well-being. This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Requires Improvement

Is the service caring?

Our findings

People and their relatives said that the staff treated them with dignity and respect, but they could not say the same for the management team or board. They gave examples of interactions of a management style that they found antagonistic and evasive. One person said at meetings they had attended with the management team, that a member of the management team said, "You should be grateful I took the time to sit down and talk to you." They said other condescending remarks had been made and gave an example of, "They (People who use the service) are quite articulate aren't they?"

Describing staff one person said, "Staff have been amazing, cheering us up. I wouldn't blame them for walking out" Another person told us, "Up until the autumn this was the best thing that happened to me for recovery. Things started to go wrong when staff started leaving." People told us that staff tried their best to provide the support they needed, but the lack of leadership, support and use of new and agency staff together, who did not know them, meant this was often not achieved to their satisfaction.

People felt distrustful of new staff, as they did not know them and had little opportunity to get to know them gradually over a period of time. They felt that the new faces were thrust upon them and they had little say in the matter. People using the service gave an example that previously part of the recruitment process was for prospective staff to be invited to meet them, current staff members and have a meal at the home. This enabled them to become acquainted with people, the home and for people using the service and the staff team to form an opinion of their suitability for the role. A person using the service said, "We would have a meeting as a community and vote if they (new staff) would fit and it would be appropriate for them to join us." This had not taken place with the newest staff recruited. The nominated individual confirmed this during the inspection process and told us that it would be re-instated in future recruitment.

Staff practices were delivered in a friendly, helpful, listening way with people's views and their opinions being valued, by all staff whilst newer staff struggled to cope with challenging situations and were reliant on more experienced staff. Although people using the service were all treated with equal friendliness and politeness, by staff, there was a marked difference in the responsiveness of people using the service to staff they knew well and those who were not familiar to them. Staff maintained appropriate boundaries and made people aware of them. People's levels of activities attended had dropped over the course of the previous two months. They attributed this to the uncertainty of their situation and lack of meaningful communication with the board, management team, new staff, losing established external therapists and feeling under pressure.

New staff carried out their duties in a caring, friendly and attentive way. However their lack of knowledge and experience about people as individuals meant that they weren't aware of or able to identify trigger points for challenging behaviour. They asked if people were happy with what they were doing and activities they had chosen. They couldn't interpret whether the answers given were an indication of possible mood change, unless it was accompanied by volatile behaviour. This was not the case with more experienced staff. One person said they were aware, in advance of cycles in their change of mood. They said new staff wouldn't necessarily be aware of them and the person did not sufficiently trust new staff to impart this information or

seek support. This problem was compounded by staff having little knowledge of peoples' past experiences and support plans not being up to date.

Each person was asked by staff if they would like to speak to us, given the time to decide for themselves and option of doing so individually or as a group and accompanied or unaccompanied by staff, depending what they felt most comfortable with. Staff promoted good, positive interaction between people using the service and promoted their respect for each other during our visit, whenever possible. They spent time engaging with people, talking in a supportive and reassuring way and projecting positive body language that people returned, particularly regarding more established and experienced members of the team.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction, on-going training and contained in the staff handbook.

Requires Improvement

Is the service responsive?

Our findings

People said that staff asked for their views and opinions, on a daily basis. They said the management team only did this when they thought they had to and paid little attention to what people told them, thought and did not act on their opinions. Previously they had been supported to make their own decisions and were given time to decide the support they needed, wanted and when it was to be delivered.

People felt they decisions were forced upon them with little consultation or consideration of what they wanted. They also said the care and support they got from the management and organisation was no longer what they wanted, delivered in a way they liked, enabling, appropriate or supportive. If they had a problem, they were not sure it would be dealt with swiftly or satisfactorily. This was repeated by relatives who gave examples of communication between themselves, the board and management team. Where before people were supported and enabled to develop life skills and enjoy a healthier life style, this had now been lost. One person said, "Decisions have been made for us, not with us." Another person said, "They (The management team) have not really explained the changes properly." A further person told us, "Decisions are made as if we are just names on a piece of paper."

During our visit people did not feel they were able to make decisions about their care and the activities they wanted to do. Activities such as external therapeutic sessions, that were not removed or were re-instated during the inspection, took place on an unstructured basis. This meant that the activities had lost a lot of their continuity and usefulness as people were aware that the activities would be coming to an end anyway.

The intended internal therapeutic programme activities proposed to replace external ones, on 1 March 2016 had not commenced. People said the uncertainty and way that changes were introduced meant that the comfortable, relaxed and enabling atmosphere that the home had previously had was replaced with one of chaos and anxiety. There was one page of A4 instructions for staff that contained five key work tasks for the two weeks prior to the launch and a basic Monday to Friday programme of daily activities. The weekly activities charts for each person were out of date and reflected activities that had previously taken place, rather than the current situation.

Previously there was a strong emphasis on people making progress towards their goal of independent living in the community and avenues open to them to achieve this. This was through a range of individual and group therapeutic activities within the home provided by external therapists and staff. People also developed through education, work and social activities within the community. One person at university was in danger of losing their place due to a lack of attendance. They said, "I have been out of contact with my university for three weeks, as I have been unwell. The university contacted me by e-mail as they were concerned. Nobody from the home contacted them." They had also been working voluntarily and attending their local church. These activities had ceased.

People told us they no longer made use of local recreational activities such as the gym, shops, theatre and pub lunches as the lack of proper support meant they were not capable of doing so. One person said, "It is hard to see everything going wrong. They also said the therapeutic sessions that included art and crafts,

women's, psycho-educational and people's process groups were not taking place and the replacement therapy sessions had not started." One person told us, "There is a new therapy programme, they (management team) took our therapies away and I have had nothing for three weeks." The home's art therapy and art exhibition to the public had also been discontinued. During the inspection some of the external therapeutic sessions were re-instated temporarily. People were expected to continue cooking one day per week, purchasing food items, clearing and cleaning the kitchen, their personal laundry, community garden project and keeping their rooms tidy. This meant peoples' life skills were maintained by taking responsibility for tasks.

Only the needs assessment for one person was in place between six people using the service and people and their relatives were not appropriately consulted or given the opportunity to choose how their care was to be delivered or about the changes being implemented. One person said, "I wanted to make amendments to my care plan, they said they couldn't find it." The care plans in place were not up to date and did not reflect the way that people's care and support was delivered. People were not enabled to discuss their choices, and contribute to their support and support plans. People said previous key working sessions with staff were not taking place. One person said, "The four to six week reviews have not taken place. Another person told us, "My keyworker was sent on two weeks training, without explanation, which is hard as I had built up a good relationship with her." A further person said, "I have not seen care plans." There was no care plan in their file.

New keyworkers were identified by the interim manager. Under the proposed changes, one person told us, "They wanted me to discuss sexual exploitation with a male, I couldn't do it." Daily notes were recorded. They were prescriptive of a person's day and contained very little practical information for staff coming on shift. The care plans were supposed to be live documents that were added to by people using the service and staff when new information became available. This was not happening. Neither were placement reviews being recorded as taking place to check that the placement was working.

The responsible individual said that if there was a problem with the placement, alternatives would be discussed, considered and information provided for prospective services where needs might be better met.

There were no up to date records that identified needs were regularly reviewed, re-assessed with people or support plans updated to reflect their changing needs. On one file the last recorded key working session was in October 2015 and on another a key working review had taken place in November 2015. The support plans that were in place recorded historic information regarding people's health, mental health, physical, psychological, emotional, educational and dietary needs. This information did not enable new staff to increase their knowledge of people as individuals, respond to their care needs appropriately or to support them in the way that people wished. We saw new staff struggling to understand how to respond to people, in an effective way, particularly in stressful situations. This meant they had to defer to more experienced staff members, if available.

People using the service were not having their needs met and their preferences were not being considered. This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

There was an admissions procedure that had not changed since the previous inspection, although new people had not been admitted to Lancaster Lodge since the change in management. The nominated individual told us that the organisation was reviewing the admission criteria, with a view to accepting people with less challenging behaviour. People were provided with written information about the home and

organisation that outlined what they could expect from the home and what the home's expectations of them and their conduct was. The home's statement of purpose was also being reviewed and changed by the interim manager to reflect the proposed new criteria for admission. It was not formalised or agreed by the board, at that stage.

There was a system for logging, recording and investigating complaints with outcomes and people told us that they were aware of the complaints procedure and how to use it. However, four people using the service and two relatives expressed frustration at the way that their complaints and concerns were responded to by the management and board and were not satisfied with the responses and actions taken. One person said that two meetings had taken place with the management team but, "I didn't feel I could voice my opinion." A relative told us, "Unfortunately, the residents have been blindsided by the changes that have consequently, left them even more vulnerable than they already are." We found scant evidence that complaints made were acted upon and learnt from with care and support being adjusted accordingly. The provider said they would review how complaints were handled.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they did not find the interim manager or nominated individual approachable or felt comfortable discussing issues with them. One person said, "The management have not made the right choices." Another person told us "The management are not mindful of how destabilising the situation is, it's traumatic." When referring to the management team and board a relative stated, "Their lack of transparency and communication from the outset has been truly despicable. Without doubt I hold them entirely responsible for her (Person using the service) demise."

During our visit the home's atmosphere did not feel open and one staff member said, "I felt spied on by others who reported back to the management team." People said they did not feel listened to by the management team and their views were routinely dismissed out of hand. They added that this did not include most of the staff team who listened to people and did their best to meet people's needs in a way that they wanted. It was clear from what people told us, the conversations they had with staff and their body language that they were quite comfortable talking to members of the staff team, they knew well. They struggled more with newer members of staff whilst bonds of trust were being established.

One person said, "I try to keep calm, but need to be informed in advance as I can't cope with change." Another person told us, "They have taken over my life and we are talked to as if we are children." Staff we spoke with said they learnt of the changes in a similar manner, without consultation. There was no written evidence of consultation except one meeting that took place, where a relative was present. The lines of communication within the organisation were not clearly defined between the board and management team. The nominated individual and interim manager were unable to name other members of the board, apart from the chairman. People and their relatives said that communication with the board was minimal and any responses received to specific questions were generalised. Staff could not recollect members of the board visiting the home or having direct contact with them.

A relative said, "Responses from the board and management team were evasive and did not clearly answer their questions." One person said, "Every decision they make they have an answer for, but it changes." Another person said, "We are talked to like we are children." One person queried why a new staff member they were beginning to bond with had been put on a two week training course just as they were building a positive relationship. They said they did not receive a satisfactory explanation. Another person also questioned why a very experienced senior member of staff was sent on training at a time when new staff required in-depth support.

Staff told us the interim manager was not very supportive. The nominated individual acknowledged that there had been some management issues as they and the interim manager also had management responsibilities for other homes in the organisation. During the inspection, the responsible person decided to take over the role of interim manager, in the short term, whilst an experienced deputy was recruited and a registered manager recruited in the longer term.

Staff said they were working hard to support each other, in what was a very challenging situation. This was

on a shift to shift unstructured basis. They said they were unprepared to discuss sensitive subjects with the management team or how they made be affected by them. Staff members they were considering leaving, as they did not want to be professionally associated with the way the home was now run. A staff member said, "We have gone from the best manager I have ever had, to being completely rudderless."

There was no evidence that a robust quality assurance system was being operated to identify how the home was performing, any areas that required improvement and areas where the home was performing well. We asked for up to date documentation to demonstrate that the quality of the service provided for people was being monitored and assessed.

The interim manager, nominated individual or staff were unable to provide evidence that the records kept were audited for accuracy and up to date. This was also reflected by the absence of up to date records of the care and treatment provided for people and decisions made in relation to it except daily notes that were prescriptive of a person's day. There were no up to date care plans in place and individual activities timetables did not reflect activities that were taking place. Neither were there assessments or monitoring of risks to people. There was one quality audit commissioned for the whole organisation from an outside consultant, who subsequently was put in post as interim manager. This was dated w/e 14 December 2015. It was one and a half pages of A4. The audit report was brief and covered strengths, atmosphere, administration and paperwork systems and other comments. It had not identified areas where improvements were required so these could be addressed.

The home failed to operate an effective quality assurance system. This constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

The interim manager left their post on 4 March 2016 to be replaced temporarily by the nominated individual. The organisation provided recruitment information regarding the interim manager and nominated individual. The post the interim manager applied for was for a clinical operational lead and did not indicate suitability or appropriate experience for the interim management role. The nominated individual's job description was for a CEO/manager of the organisation. Under essential skills and knowledge the person specification required a good understanding of mental health and therapeutic environments and their development. The recruitment information provided did not demonstrate that either of the two managers' had experience of working directly with this client group.

Persons employed for the purposes of carrying on a regulated activity did not have the qualifications, competence, skills and experience which are necessary for the
work to be performed by them. This constitutes a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

Our records showed that appropriate notifications were not made to the Care Quality Commission in a timely way. There were five instances of people being admitted to hospital under section of the Mental Health act 1983 between 1 February 2016 and 10 March 2016.There was no evidence that the provider had notified us of this. These instances included police or paramedic intervention. When asked about this the interim manager and responsible person did not display knowledge of the circumstances under which these notifications should be made.

Required notifications were not made to the Care Quality Commission. This is a breach of Regulation 18, of the Care Quality Commission (Registration) Regulations 2009.

The organisation's vision and values were being redeveloped and a new statement of purpose was being completed. The people we spoke with and their relatives said they had very little participation in and were not consulted about proposed changes to the way the home ran and changing admission criteria. They told us they were presented with the changes, in a manner that suggested the decisions were already taken and they could take it or leave it.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in need and support as required. We did not find evidence that this was being followed in the two months prior to our visit except when calling the police or paramedics. This meant that suitable support may not be provided or peoples' needs appropriately met.