Cambian Healthcare Limited

Cambian Ash Lea House

Inspection report

Brookhouse Lane
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Tel: 01782303366

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08 September 2016

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We inspected this service on 8 September 2016. This was an unannounced focused inspection that we completed in response to safety concerns that had been shared with us. This was the service's first inspection since they registered with us in September 2015.

The service is registered to provide accommodation and personal care for up to four people. People who use the service are between 16 and 25 years of age and have complex needs which may include a mental health condition and/or a learning disability. At the time of our inspection three people were using the service.

The service did not have a registered manager. 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. A new home manager had been appointed and they told us they were planning on registering with us.

At this inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's health, safety and wellbeing were not always assessed, managed or reviewed to promote their safety. Safety incidents were not always reported promptly and action was not taken to prevent further safety incidents from occurring. Medicines were not always available to keep people safe and well.

There were not always enough staff available to keep people safe and meet people's individual care needs.

People were not always protected from the risk of abuse or improper treatment.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed to promote their safety. Medicines were not always available to keep people safe.

There were not always enough staff to keep people safe and meet peoples care needs in a prompt manner.

People were not consistently protected from the risk of abuse and improper treatment. Potential safeguarding incidents were not reported as required and effective systems were not in place to ensure restraint was practiced appropriately and safely.

Cambian Ash Lea House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Ash Lea House on 8 September 2016. This inspection was completed in response to anonymous safety concerns that had been shared with us.

We inspected the service against one of the five questions we ask about services: is the service safe? This was because the concerns we had received all related to safety at the service. Our inspection team consisted of one inspector.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

We spoke with two people who used the service, three members of care staff, the home manager and the provider's senior homes manager. We did this to gain people's views about the care and to check that standards of care were being met. During our inspection, we also spoke with a social worker to share our concerns about people's safety. We did this because we believed people were at risk of significant harm to their health, safety and wellbeing.

We spent time observing how people received care and support in communal areas and we looked at the care records of three people to see if their records were accurate and up to date. We also looked at staff rotas to check staffing levels.

Inadequate

Is the service safe?

Our findings

People told us they did not always feel safe at Ash Lea House. One person told us how they didn't feel safe during a recent incident at the service. They said, "I didn't feel safe then [during the incident], I went and hid in the games room". Another person had recently told the provider they felt the home was, 'unsettled'. All the staff we spoke with, with the exception of the provider's senior homes manager told us they felt they were unable to keep everyone who used the service safe. This was because staff said they didn't have the information and resources they needed to do this. For example, they didn't have access to the equipment needed to keep people safe. Safety incident reports we viewed confirmed what people and staff told us. These records showed that a high number of safety incidents had occurred and people's safety was not consistently supported.

Safety incidents were not always reported or investigated in a timely manner. For example, records showed that one safety incident was reported nine days after the incident occurred. This meant immediate action had not been taken to reduce the risk of further incidents from occurring. We also found that action was not taken by the provider to ensure risks of further safety incidents were reduced. For example, one person's records showed they had been involved in at least 18 safety incidents over a 15 day period. No effective changes had been made to their agreed care to reduce the risk of further safety incidents occurring. This meant the provider was not effectively acting upon concerns to promote people's safety and wellbeing.

We found that risks to people's safety and wellbeing were not always assessed and planned for. For example, staff told us they were only aware that one person had a medicines allergy as they had overhead a visiting health care professional discuss this with another member of staff. The person's pre-admission assessment and care plan did not record their allergy. This meant there was a risk that important health information would not be passed on in an emergency situation because the information was not effectively recorded or handed over to the staff. We ensured that the staff clearly documented this information in the person's care records before we finished our inspection. Records showed that another person had informed the provider that recent changes to the service had affected them 'emotionally and mentally'. This person also told the provider that they felt they needed to keep their emotions to themselves as they didn't want to give the staff any extra problems. This had not triggered any changes in the person's care. No plans were in place to offer this person any extra support during a time where they felt unsettled, despite the increased risk of harm to their health and wellbeing. Staff told us that although they were aware of this person's current needs, they were not always able to support this person if they were reluctant to tell them if they were feeling vulnerable as they would not know when this person required additional support. This meant there was a risk that the person would not receive the support they needed because they felt unable to approach staff for support.

Medicines were not always available to keep people safe. One person told us and care records showed that at times they required a specific medicine to keep them safe and well. This medicine was not available at the service and the risks associated with this medicine not being available had not been assessed or planned for. This meant the person was at risk of harm to their health, safety and wellbeing.

Where risks to people's safety had been recognised and planned for, we found that care was not always delivered in accordance with their agreed care plan. For example, records showed that staff needed to keep safety equipment on their person so it could be used in an emergency situation. Staff told us and we saw that this equipment was being stored in a drawer in a locked room rather than on their person because the equipment was not fit for purpose. Records showed that this piece of equipment had been needed in an emergency situation on at least seven occasions in the 15 days prior to our inspection. This meant people were at risk of harm because the safety equipment they needed was not readily available as planned. We informed the provider of this significant safety risk during the inspection and new, suitable equipment was made available for the staff to use as planned on the same day.

People and staff were not always aware of the specific support needed to promote safety at the home. For example, one person and the staff who supported them were not aware of the agreed level of observation that was needed to keep them safe. The person's records did not clearly record the support they needed which meant it was not available for staff to refer to. When we spoke with the person and the staff about the agreed observation level, they confirmed they were not consistently receiving this support. Staff rotas also showed and we saw that this person was not consistently in receipt of their agreed level of support.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were not always available to enable them to do the things they wanted to do, when they wanted to do so. One person told us they had recently been unable to attend their preferred activity as staff were unable to facilitate this. Records showed that another person had expressed concerns to the provider that they were unable to access the support networks around them because of the recent changes at the service. Staff rotas showed that on occasions there were not enough staff on duty to keep people safe in accordance with their agreed plans of care. For example, staff told us that the minimum staffing numbers required at the service were three staff. Staff rotas showed that on the 15 days prior to our inspection, there were five days/nights where only two staff were working at the service. This meant that on these occasions, there were not enough staff to meet the needs of all the people who used the service. During our inspection, we told the provider that their current staffing levels were unsafe and people were at risk of harm to their health and wellbeing as a result of this. The provider responded to our concerns by agreeing to immediately increase their staffing levels.

The above evidence shows that effective systems were not in place to ensure adequate staffing levels were maintained to consistently promote peoples safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of abuse and improper treatment. One staff member told us about a potential safeguarding incident they had reported to the provider's senior homes manager. The details of this incident had not been recorded in the person's care records. The senior homes manager told us they had discussed this concern with the person's social worker. However, there was no evidence of this in the person's care records. Therefore we could not be assured that the incident had been reported as required. Safeguarding concerns should be immediately reported to the local authority so they can consider if any action is required to manage or minimise further incidents from occurring.

Incident records showed that at times staff used physical restraint to respond to people's behaviours. The Department of Health's Positive and Proactive Care: reducing the need for restrictive interventions 2014 states, 'Where unplanned or unintentional incidents of restrictive practice occur there should always be

recording and debrief to ensure learning and continuous safety improvements'. Incident records did not always detail important information about the restraint. For example, the duration of the restraint and the specific type of hold. This meant the provider could not check that staff were using restraint appropriately and safely.

The above evidence shows that effective systems were not in place to ensure people were protected from the risk of abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people consistently received their care in a safe manner.

The enforcement action we took:

We served a warning notice to the provider that required immediate improvements to be made by 23 September 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems were not in place to ensure people were protected from the risk of abuse and improper treatment.

The enforcement action we took:

We served a warning notice to the provider that required immediate improvements to be made by 23 September 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective systems were not in place to ensure adequate staffing levels were maintained to consistently promote peoples safety.

The enforcement action we took:

We served a warning notice to the provider that required immediate improvements to be made by 23 September 2016.