Advance Housing and Support Ltd

27 Islip Road

Inspection report

27 Islip Road
Summertown
Oxford
OX2 7SN
Tel: 01865 554920
Website: www.advanceuk.org

Date of inspection visit: 11 March 2015
Date of publication: 23/04/2015

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We inspected the service on 11 March 2015. The service is registered to provide accommodation for up to 10 people with a learning disability who require personal care. At the time of the inspection there were eight people living at the service. This was an unannounced inspection.

We previously inspected the service on 3 January 2014. The service was meeting the requirements of the regulations at that time.

Prior to this inspection we had received concerns from the local authority and visiting health professionals about how the risks associated with peoples care and support were managed and how the service was being led.

People were at risk of unsafe care and treatment because their risk assessments and other records relating to their care were not always accurate or up to date. Some risks to people had not been identified. Where risks had been identified guidance was not always provided to care staff to support people safely and effectively. People were not adequately assessed by the service. People and their

Summary of findings

relatives were not involved in assessments and care planning. The service was not adhering to the key principles of person centred care. Information about some people was not managed in a way that protected their privacy.

People were not always supported with their care in a way that was respectful or promoted their independence. Medicines were not always stored or managed safely.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager demonstrated a personalised approach and a commitment to providing good quality care, but required further support to make changes to bring the service up to the required standard. Systems were not in place to monitor the quality of the service and there was a dependence on external professionals to identify areas where improvements were required.

People, their relatives, and staff recognised that improvements were taking place and attributed this to the work of the registered manager.

People felt safe and their relatives told us they did not have concerns about people's safety. People were protected from abuse. There were effective systems in place to support people to manage their finances. Staff were knowledgeable about the types of abuse and what action to take if they thought people were at risk. People were supported to maintain relationships and express their sexuality in a respectful way.

People told us they liked living at the home and were treated in a friendly way. People and their relatives were very complimentary about the registered manager and staff. People liked the food and were supported to maintain a healthy diet.

Some improvements had recently been made to the service to ensure people lived in a comfortable and homely environment. However some further improvements were still required.

Staff did not fully understand the Mental Capacity Act 2005 (MCA), so the principles of the act were not being followed to ensure people who might lack capacity were being supported to make decisions.

Staff felt supported. However, staff were not supported to improve the quality of care they delivered through training or the supervision and appraisal process. Although staff had recently received training in some areas such as the MCA, risk assessments and care planning we found staff knowledge and practice in these areas required improvements. This meant the training had not been effective in meeting the needs of the people they were supporting.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see the action we took and what action we told the provider to take at the back of the full version of the report. Following the inspection we shared our findings with the local authority commissioning and safeguarding teams.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People did not benefit from a robust risk assessment process to keep them safe.

Medicines were not always stored or managed safely.

People told us they felt safe. Staff were knowledgeable about the procedures in place to recognise and respond to abuse. There were contingency plans to keep people safe during unforeseen events. Safe recruitment practices were followed.

Is the service effective?

Inadequate

The service was not effective. Staff were not supported to improve the quality of care they delivered through training or the supervision and appraisal process.

People were not supported by staff who understood and embedded the principles of the Mental Capacity Act 2005 (MCA).

People did not benefit from accurate and up to date health action plans.

People enjoyed the food and were supported to maintain a healthy diet. However, people were not always supported to be involved in meal planning.

Is the service caring?

Requires improvement

The service was not consistently caring because people were not always supported in a respectful way.

People were complimentary about the care they received. People told us staff understood their needs and were friendly and caring.

People were supported to maintain relationships and express their sexuality in a respectful way.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. The principles of person centred care planning were not adhered to. People were not involved in the assessment and care planning process. Assessments did not always provide instructions on how to support people. Records relating to peoples care were not always accurate, legible or up to date.

People benefited from regular activities but would have liked the opportunity to try different things.

People and their relatives knew how to make a complaint and felt confident any concerns would be responded to.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. Effective quality assurance systems were not in place. Where concerns had been identified some actions to improve the service had not been completed.

The provider had not always notified the Commission of some incidents, which they are legally required to do.

People, staff and relatives were complimentary about the manager and the improvements they had made since they had been in post.

Although the manager had some understanding of the changes and improvements they required further support to bring the service up to the required standards.

27 Islip Road

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 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.

This inspection took place on the 11 March 2015. It was unannounced. The inspection team consisted of two inspectors.

Prior to our visit we reviewed the information we held about the service. This included notifications, which is information about important events the service is required to send us by law. We also received feedback from three health or social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with four people and four people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, the area manager and four care staff.

We looked at records, which included six people's care records, the medication administration records (MAR) for all people at the home and four staff files. We also looked at records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with felt safe, one person told us, "I feel safe here", another person told us, "Yes I'm safe". All of the relatives we spoke with told us they felt people were safe living at the service especially since the registered manager had been in post. However some visiting professionals had raised concern about people's safety. One professional told us, "I am not confident people are always safe, there has been a lot of involvement to help the service develop their skills".

People were not always kept safe through the risk assessment process. People with learning disabilities should have person centred risk assessments so they can receive the correct level of support to live their lives in the way they want. People had some person specific risk assessments in place that clearly detailed risks for specific occurrences such as accessing the community and going swimming. However, the actions documented to keep people safe were not always followed. For example, one person had a risk assessment which stated "they should not be out alone". On the day of the inspection this person they went out alone. Other risk assessments were generic and not person centred. For example, one person had been identified as at risk of falling. They had a generic risk assessment relating to cooking, first aid, trips slips and falls. This risk assessment did not adequately identify the individual risk to them or detail subsequent action staff should take to keep them safe.

Risk assessments were not reviewed when they should have been. For example, one person had a risk assessment in relation to a medical condition. It was documented that this risk assessment should be completed monthly. The monthly review had not taken place since December 2014. Another person had a section of their care record where three documents called "risk assessment review" were filed. Two of them were blank and one had a risk score documented on it and a note from a GP but did not document what risk was being referred to. This meant important information about risks for the person and how to keep them safe could be missed.

Staff told us about, and care records confirmed, some areas where people were at risk, but there was not a risk assessment or corresponding plan of care in place for staff to follow to keep people safe. For example, one person had a document called "things that are important to me", this identified that the person experienced swallowing difficulties. It stated this person "needed their food to be wet and in small pieces, they should not have fat such as bacon rind and fruit should be without pips." We observed this person being given bacon, beans and hash browns for their evening meal. There was rind on the bacon and the meal had not been cut into small pieces. We alerted a care worker who then cut the food. There was no risk assessment or care plan to inform staff what action would need to be taken if this person experienced an episode of choking or aspirated any foods. This person had not been referred to a speech and language therapist for assessment in relation to their swallowing difficulties.

Support was not always delivered in a way that safely met people's needs. We reviewed one person's file who sometimes displayed behaviour that could result in self-injury or present as challenging to others. Guidelines did not clearly state how this person should be supported in order to prevent incidents from occurring. We saw there was no monitoring of this behaviour to identify risks, triggers or trends that could be used to support this person. We observed two escalating incidents involving people. At no point during the observation did staff intervene to support the calming of these situations.

The registered manager had a system to record incidents and accidents. This system included a section for the manager to review and state actions to prevent future incidents. We reviewed all the incidents and accidents that had occurred in the last year. We saw incidents were being clearly recorded. However, it was not clear whether these incidents were being monitored and whether action had been taken. For example, we looked at an incident where money had been taken form a person by another person. The incident was reported in line with safeguarding procures and investigated, but no changes were made to this person's support plan or risk assessment. Another person had fallen when crossing the road, there was no change to the person risk assessment or support plan to help prevent further incidents.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where risk assessments had been completed by external health professionals to ensure the safety of people, these

Is the service safe?

were not always stored so they could be located promptly when required. For example, one person had a medical condition called epilepsy. The risk assessment in place in relation to this condition was stored in a clear plastic file pocket in between two other risk assessments. These risk assessments were also not filed in the section of the care record titled 'risk assessments'. This meant the instruction and guidance in the risk assessment for staff to support this person was not readily available.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. For example, any known allergies people had were not documented on medicine administration records. The date that creams and liquid medicines had been opened or the expiry date was not recorded. This could mean medicines that were no longer effective could still be given to people. Medicines were stored in locked cupboards in the staff office. The office was unlocked and accessible to people who used the service. There was an unlabelled bottle of cough medicine stored in a visible place. The registered manager told us they thought this belonged to a member of staff.

People did not have individual protocols for medicines prescribed to be taken as required (PRN). This meant there was not sufficient guidance to staff on when to administer the medication. For example, one person had two different pain relieving medicines prescribed. We spoke with three staff who were responsible for administering the medicines. They all had a different interpretation of when the person would require these medicines which meant the medicine might not be administered consistently.

Staff checked medicines supplied in monitored dosage systems (MDS) against medicine administration records at every handover to ensure that people had been given their medicines in line with their prescription. We were unable to check if people who had medicines that were not supplied in MDS had received these in line with their prescription because quantities received from the pharmacy or carried forward balances were not kept.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff to meet people's needs. Any shortfalls in the planned number of staff were covered by agency staff. The same agency staff were used to ensure consistency and continuity of care.

People were protected against the risk of abuse. Their finances were managed in a safe way. Staff were aware of the potential types of abuse and knew how to report any safeguarding concerns and felt confident in raising any Issue within the organisation and also by following the whistleblowing policy.

The service had plans in place to keep people safe during an emergency. This plan had recently been followed when the homes boiler was not working effectively. People were moved to a nearby hotel then chose to spend a week at a holiday camp whilst repair work was carried out. People told us they had enjoyed this holiday.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

Inadequate

Is the service effective?

Our findings

People were not always cared for by suitably skilled staff. For example, although staff had received recent e-learning training in the Mental Capacity Act, care planning and risk assessments we found staff did not have good knowledge in these areas and shortfalls were identified in peoples care records.

Staff felt supported and told us they received individual one to one supervision, but "not as regular as planned". The registered manager told us supervisions had not been carried out as often as they had been planned because attention had been focused on other areas where the service required improvement. Not all staff files we reviewed contained evidence of supervision and appraisal. We were shown a recent supervision for three staff. The registered manager told us previous supervision records for these three staff and other staff working at the service had been archived. Although archived records were stored at the service these could not be found.

These issues were a breach of Regulation 23, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not benefit from a service that fully understood and embedded the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals. Most staff did not have an understanding of the MCA. Two staff told us the MCA was about how they managed people's behaviour. There was no evidence through people's care records to show that where people needed support with decisions this was being done lawfully. We discussed this with the registered manager and area manager who acknowledged there needed to be an increased awareness of the MCA.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People with learning disabilities often have unmet physical healthcare needs and so Health Action Plans (HAPs) were introduced by the Department of Health. HAPs hold information about people's health needs, the professionals who support those needs, and people's various appointments. People at the service told us they had access to other healthcare professionals such as the GP, opticians and dentists. However, HAPs did not always contain accurate and adequate detail. For example, in one person's HAP it recorded there were no issues in relation to their dental care. However, this person was having on going dental treatment and was recommended to have a soft diet due to the problems with their teeth. In another person's HAP staff had written in the section for the last dentist visit "not recorded". One person had a medical condition called epilepsy but in the section titled 'I have epilepsy' "no" had been recorded. Staff had recorded a date when a person should have attended the optician, which had passed at the time of our inspection. There was no further documentation in this person's care record about whether they had attended the appointment or the outcome of the appointment. We discussed this with the registered manager who showed us an entry in the diary that showed this person had refused to attend the appointment. They were unsure if a further appointment had been arranged.

These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food at the service. Fruit and drinks were readily available for people to help themselves. What people had eaten was discussed at handover to ensure people had eaten sufficient quantities. One person had expressed a wish to lose weight. They had been referred to a dietician and were waiting for an appointment in relation to this. Staff told us that people were involved in meal planning. However, one person told us "I don't plan the food, staff do it". Another person also told us they were not involved in the meal planning. They said, "we don't get to choose we just get given the food".

Inadequate

Is the service effective?

There was awareness within the service that the environment required improvement. The service was considering possible moves to new premises. Inside the home efforts had been made to ensure the property was homely and designed in a way that could meet people's needs. For example, the layout of quiet rooms enabled people who may need to take space to do so. People's bedrooms were comfortable and furnished and decorated in the way they chose. However, there were elements of the environment that did not receive the same level of consideration. For example, toilet role holders were falling off the walls, in the dining room the dining table was unstable and pictures were hanging crookedly on the walls. One picture in the hallway fell off the wall and hit an inspector, this had been on a small hook but stabilised with blu tack. The garden was untidy and flat footballs were left lying around.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has been supported by the local authority to understand their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may need to be deprived of their liberty to keep them safe. An urgent application had been recently made to restrict someone of their liberty for their safety. Where a short term restriction was in place people were supported in the least restrictive way.

Requires improvement

Is the service caring?

Our findings

People were not always treated in a respectful way. One person was given money when they were going out. They told the staff member they did not have enough money. The support worker had not asked how much they needed and questioned them about why they would need more. A support worker asked a person why they were going to the doctors in a room full of other staff and inspectors. The person looked uncomfortable and did not reply.

On a number of occasions we observed one member of staff be loud and abrupt. It was clear on one of these occasions one person had not understood what was being communicated. The staff member repeated their question, in the same manner but louder. The person became visibly upset as he felt he'd been shouted at. On another occasion we saw one person was upset. Whilst we observed the staff member to be calm and attempting to be sympathetic, they made no attempt to understand why the person was upset and kept telling the person to, "just forget about it" in an attempt to reassure.

There was confidential information about people on the walls of the office. Service users went into the office. One person who had been in the home for over two years still didn't have their name on the routines for the house, instead their name had been written over the top of another person whose name had been scribbled out.

New apples had been laid out in a fruit bowl on top of older apples that were beginning to rot underneath. We observed service users helping themselves from the fruit bowl.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with felt their needs were understood. One person told us, "my key worker gets me". Another person told us, "my key worker understands me". People engaged well with their key workers and other staff that were responsible for their one to one support. However, this understanding of people was not shared across the team within the culture of the home and meant people did not always build supportive relationships with other staff. For example, we observed people without support or engagement for long periods of time. When staff entered the room they mainly focused on one or two individuals. We saw one incident that had been recorded stated that a person had refused to come back to the home because their keyworker wasn't there.

People we spoke with felt cared for. Comments included, "staff are very caring", "I am really cared about, staff make me laugh", and "they [staff] are very friendly and helpful and jokey. They make me laugh". A relative said, "he [their relative] is happy, he wants to go back when he's been out".

Some people wanted to show us their rooms, where they had items relating to their interests. They told us that they were encouraged to be as independent as possible in keeping their room tidy and clean.

People were supported to express their personal relationships and sexuality in an appropriate way. People and staff had been involved in identifying how this could be managed safely and sensitively without being intrusive.

Inadequate

Is the service responsive?

Our findings

People did not benefit from a service that understood the principles of person centred planning (PCP). PCP is a recommended approach for supporting people with learning disabilities from the British Institute of Learning Disabilities (BILD). PCP is used to enable individuals with disabilities, or otherwise requiring support, to increase their personal self-belief and improve their own independence. PCP is a method of planning personalised support for people who may be disempowered by traditional methods of support. PCP involves continual listening and learning, focusing on what is important to someone now and in the future, and acting upon this in alliance with their family and friends.

People's information was not personalised and did not involve people's friends and families. Support plans were being written outside of the service without the involvement of people.

People's needs were not assessed by the service. The service relied on functional analysis in care environment (FACE) documents to inform support plans. The registered manager acknowledged there had been a number of occasions where these FACE documents had not contained key information about people. Despite this an assessment of the person's needs had not been carried out by the service.

Information about people's history was not always used to inform their support plans. For example in two care records we looked at we saw information regarding key events that were not referred to in their support plans. Staff did not understand the significance of these events so would not be able to support people effectively at times of distress. One person had significant information that had not been shared with some staff. We discussed this with the manager who told us, "we only share as much as we think people need to know". Whilst we understood the need to respect people's privacy, the ability of all staff to support people effectively was compromised by not knowing this information.

People benefited from a range of activities both in their home and through day services. We observed people doing craft and enjoying their own games. We also saw people arranging a cinema trip and planning to go to a regular club. However, we found many people accessed the same services as a matter of routine and not necessarily services that supported their social inclusion. One person told us, "I would like to try different things". Another person told us, "we just have to follow my plan for the week; I would like to do more". One person had expressed a wish to do more cooking. People told us they were not involved in helping with the cooking. When we spoke with staff about this they told us this was because there could be a risk to people to do so. People's levels of independence had not been assessed in this area.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was limited and inconsistent information about people's strengths and levels of independence. Some care records contained life story information; others contained 'about me' documents. However, in the care records we reviewed these were not always completed in a way that helped staff understand the person. We spoke with people about their dreams and aspirations regarding what would be a meaningful life for them. This information was not recorded. People had documents called 'essential life plans'. However, these were tucked away behind other paperwork and were not always completed fully. Some documents held conflicting information and did not make people's preferences clear. We discussed this with the Area Manager who acknowledged that the care records could be clearer and contain better information.

People's changing care needs were not always documented clearly in people care records. For example, in one person's care record it made reference to a serious skin condition that would have had implications for other people in the home and people close to the person. We discussed this with the registered manager who told us this person did not have this condition. They told us this person had a less serious condition that was brought on by anxiety. This information was not documented. There was a risk this person may have been treated differently as a result of this information not being clear in their records.

Other key documents in people's records were not completed or were not accurate. For example, one person had a document in their care record that had not been completed. This document was intended to be a one page "quick glance" to inform staff what care people required.

Inadequate

Is the service responsive?

This contained information such as what medication a person had, if they had any allergies and information relating to any medical interventions. Another person had a document called “a hospital grab sheet”. They had some medicine for a specific medical condition. This medicine was not listed on the current medicines section of this document. This meant this document would not be able to inform this person’s care if they were admitted to hospital.

One person, when we were looking through their care record told us, “I don’t like these bits falling out”. This was due to documents not being secured in the file. People had some daily care records that were difficult to read due to illegible hand writing. This would make it hard for care staff when writing the notes to see what was previously recorded about this persons care.

These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew how to make a complaint and the provider had a complaints policy in place. This was provided to people in an easy read format. People told us, "I tell the manager if I am not happy”. Another person told us they had been supported to change keyworkers. They said, “I wasn’t happy. I asked for a new keyworker to help me”. People were supported to attend a weekly “customer meeting” where they were also invited to share their views about the quality of the service. A recent quality assurance survey where people and their relatives had been asked about their views on the service had taken place. The registered manager told us the forms were sent to the provider and they had not yet been made aware of the results.

Inadequate

Is the service well-led?

Our findings

There were arrangements in place for involving people in the way the home was run. For example, people helped staff complete a regular health and safety audit of the premises. However, the registered manager was not able to show us any other audits that had been completed to demonstrate they had monitored the quality of the service. There was also no evidence available to show the quality of the services provided in the home were monitored at a more senior level within the organisation. There was also a lack of proactive managerial oversight to ensure that risks to people's safety and welfare were being identified, assessed and managed.

The lack of quality and risk auditing and the impact on peoples care and safety was demonstrated through the breaches of regulations we found during this inspection. The breaches also demonstrated how the service was not always meeting people's needs.

The service did not always demonstrate an understanding of why people displayed certain behaviours or implemented plans, risk assessments and strategies to support people and to keep them safe. The registered manager was unable to make important changes to the care and treatment provided to people as there was no reliable analysis of incidents that resulted in harm or had the potential to result in harm.

The local authority had reported some concerns about the quality of the service in October 2014. Despite some help and support from professionals to make improvements, the registered manager and provider had not taken action to address all of the issues that had been identified. For example, some issues were in relation to people not being protected against the risks of unsafe or inappropriate care and treatment due to missing, inaccurate or unclear records and risk assessments.

The service was disorganised. The offices we spent time in were untidy many of the walls of were posted with out of date notices and some documents relating to the running of the home were not able to be located.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was not always sending us notifications. Notifications are information about important events the service is required to send us by law. Prior to the inspection the local authority told us about some incidents that had not been reported to us. We addressed this with the area manager who then sent us the notifications. During the inspection we checked to see if subsequent notifications had been made. We found a further incident the registered manager should have notified us about but had not done so.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was approachable and open and showed a good level of care and understanding for the people within the service. However, we observed that whilst the registered manager was leading the day to day running of the service, there was a lot of dependence on external professionals to provide an overall sense of safety. We raised this with the registered manager who acknowledged that the leadership of the service needed to be stronger to ensure they were meeting the requirements of their own registration as well as that of the service.

The provider had identified that the registered manager required additional support to make the changes to bring the service up to the required standard and a new area manager had commenced employment with the provider in January 2015. They were spending two days a week at the service to support the manager in making the required improvements.

The registered manager had been in post since August 2014 and registered as a manager with the CQC in October 2014. Since the registered manager had been in post they had worked hard to change the culture of the service. People, their relatives and staff were very complimentary about the registered manager and spoke positively about the changes and improvements they had made since being in post. One person said "it's better since she [registered manger] came". One relative told us the care had been poor before the registered manager had started. They told us The registered manager "has had to take over the mess" and they were "warm and welcoming and gave every one a confidence they haven't had before. She has introduced a new life". Another relative told us that since the registered manager had been in post "everything is such an improvement. Even just walking into the home the atmosphere is now warm and homely" and "as far as we

Inadequate

Is the service well-led?

are concerned she is doing a brilliant job". Other comments from relatives were the registered manager has "really turned the place around" and "they have made that house a happy place". A member of staff told us the registered manager "has really lifted the place since she has been here".

The registered manager told us that people and staff had previously been informed that the service was to be closed and people would be moved to a new home and the existing care staff might not move with them. There still seemed to be some anxiety around whether this service would remain open. The registered manager felt this uncertainty had impacted on staff's motivation and affected the quality of service that people received. Relatives told us they had been present at the meeting where people had been informed about the move and this continued to be very worrying for people and their relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Appropriate arrangements were not always in place for managing medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure that the principles of the Mental Capacity Act 2005 were appropriately implemented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured that service users were protected from the risks of inappropriate care and treatment because an accurate record in respect of services users including appropriate information had not always been kept. Records could not always be located promptly when required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their

This section is primarily information for the provider

Action we have told the provider to take

responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training, professional development, supervision and appraisal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not made the commission aware of some notifiable incidents. Regulation 18 (2) (e)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not take proper steps to ensure people always received care that had been planned or delivered in a way that met their individual needs or which ensured their safety and welfare.

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice telling them they are required to become compliant with regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 30 May 2015.

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person did not make suitable arrangements to ensure people were always treated with respect, maintain their independence or be involved in decisions relating to their care and treatment.

The enforcement action we took:
The registered provider must not accept any further service users without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to monitor the quality of the service delivery. Effective systems were not in place to identify, assess and manage risks.

The enforcement action we took:
The registered provider must not accept any further service users without the prior written agreement of the Care Quality Commission.