Aspire Specialist Care Limited

Saint Josephs Specialist Care Home

Inspection report

44 Newbold Road, Chesterfield
Derbyshire. S41 7PL
Tel: 01246 239752
Website: www.aspirecaregroup.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We completed an unannounced inspection of Saint Josephs Specialist Care Home on 14 January 2015. A second day of inspection took place on 27 January and the manager was given notice the day before so they could make arrangements to be available at the service.

Saint Josephs is required to 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 2008 and associated Regulations about how the service is run.

Saint Josephs Specialist Care Home registered with the Care Quality Commission on 13 December 2013 and had not previously been inspected.

Summary of findings

Saint Josephs is a care home for up to seven younger adults with learning disabilities or autistic spectrum disorder who require specialised care and support. At the time of our inspection six people were supported to live at the service.

At this inspection we found risks associated with the use of restrictive physical interventions (RPI). RPI was being used by staff to restrain people in the service when their behaviour was causing a risk to themselves or others. However, it was not being appropriately managed to ensure the safety of people using the service. Other plans to manage foreseeable risks, for example, how to keep people safe should the building need to be evacuated were also not in place. We also found records of accidents and incidents were not always completed or used to identify how risks could be reduced. Systems for the safe management and administration of medicines were not in place. Some people were prescribed medicine 'as and when' they required it but there were no guidelines in place to ensure staff administered this medicine consistently.

We found procedures were not effective at assessing and monitoring the quality of services and identifying, assessing and managing risks. Appropriate authorisations under the Deprivation of Liberty Safeguards (DoLS) had not been requested for some people living at the service.

Recruitment practices were not robust and staff started work before Disclosure and Barring Service checks had been received. Staff practice was not always consistent with the support identified in people's care plans. This included having insufficient members of staff available to provide the level of support identified. Staff did not receive supervision as often as required and appraisals were not always fully completed to ensure staff members received comprehensive feedback on their performance. We found that staff were motivated and wanted to do their best for people using the service. However, some staff told us the length of time they spent at work due to a shortage of available staff and the lack of support they felt they received was having a negative impact on them.

People told us the manager and director were visible, however some people we spoke with told us they felt the management style was not open and approachable. One person who used the service had been worried about our visit because of what a staff member had told them. Some staff told us they did not feel the ideas they suggested to make improvements were listened to.

Families and other professionals were mostly positive about the service and told us about the amount of effort staff members had made to understand and support the people living at the service. However, some people told us they were concerned over the service not supporting people to access appointments with other professionals for health checks. No complaints had been received by the service since it opened. However, the service had not yet developed ways, other than through the complaints process, to gather feedback from people involved and to develop and improve.

People were supported to make healthy living choices and this included being able choose food that supported a healthy lifestyle. We could see that people's views and preferences were understood by staff and that people had been supported to take an active part in some aspects of planning and reviewing their care. People's independence was respected and supported and people took part in activities they enjoyed. People were also supported to gain confidence through participating in activities with staff support and motivation.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People had experienced care that was not safe because the guidance had not been followed. We also found risks identified at the service were not properly managed. Staff started work without relevant checks on their suitability for the role applied for.

Inadequate

Is the service effective?
This service was not effective.

Where people did not have the capacity to consent to their care the appropriate authorisations and decision making processes had not been completed and reviewed. We also found staff had not been provided with suitable levels of supervision. People were supported to maintain a healthy diet.

Requires improvement

Is the service caring?
The service was not consistently caring.

Although we observed staff to be caring in their approaches they had not always considered people's emotional well-being.

Most families told us they felt included and involved with the care of their relative. Staff helped to create a fun atmosphere for people using the service and supported people to be independent.

Requires improvement

Is the service responsive?
The service was not responsive.

Actions were not always taken in response to risks and processes to enable feedback had not been fully developed. However, people were supported to pursue their interests and hobbies and people received appropriate support to enable their confidence to develop.

Requires improvement

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

Procedures designed to assess and monitor the quality of services and manage risks had not been working effectively. People's experiences did not support the view that there was always an open and transparent culture at the service.

Inadequate

Saint Josephs Specialist Care Home

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 January 2015 and was unannounced. A second day of inspection took place on 27 January and the manager was given notice the day before so they could make arrangements to be available at the service.

On the 14 January the inspection team included an inspector and a specialist professional advisor whose area of specialism was in mental health and autism. On the 27 January the inspection team included two inspectors.

We spoke with three people using the service and seven relatives of people using the service. We also spoke with three social care professionals and two health care professionals who were involved in supporting people's care at Saint Josephs Specialist Care Home. We spoke with six members of staff including the registered manager and the director.

We observed how staff spoke with and supported people living at the service and we reviewed the care records for the six people living there. We reviewed other records relating to the care people received. This included staff recruitment, training and supervision records, accident and incident records and medicines administration records.

Inadequate

Is the service safe?

Our findings

One person we spoke with told us they felt okay living at the service. Another person we spoke with told us they felt safe and trusted staff but they felt worried by the amount of restraint used for one person. A third person we spoke with told us they didn't always like the other people that lived in the service. We found that staff had recorded this person wanted to leave the service as they had been hit by another person. There was no record of support for this person or details on how this issue had been investigated and resolved.

During our inspection we found some people using the service had been restrained by staff with restrictive physical interventions (RPI). RPI was being used by staff to restrain people in the service when their behaviour was causing a risk to themselves or others. Guidance for one form of RPI used in the service stated it should only be used as a last resort. One person had been restrained on eleven separate occasions over a period of five months using this form of restraint. We saw no evidence on their support plan of when this restraint should be used or which other techniques staff could use, as a less restrictive option, to reduce the need for physical restraint.

The guidance also stated that the use of this type of RPI should be reviewed every three months and staff should work towards a reduction in its use. We saw no review for the use of this type of restraint, even though it had been used on one person for a period of five months. There was no analysis of each incident of restraint to ensure it had been used appropriately and in the person's best interests. Therefore suitable arrangements were not in place to protect people against the risk of potentially excessive control or restraint.

We found that one form of RPI used in the service required three members of staff for it to be used safely. We found that this RPI had been used on people using only two members of staff, on four separate occasions. Three of these incidents of unsafe RPI had not been identified as potentially abusive and therefore had not been referred for safeguarding investigation. No effective action had been taken to prevent this happening again.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

We saw two other people had been restrained using various RPI techniques on a number of occasions. Their care plans did not contain any information on the type of RPI that had been assessed as suitable and safe for use with them. Individual risks to people being held in the different restraints had not been identified. People's care plans did not contain clear guidance for staff to follow to de-escalate incidents or clearly identify when physical restraint was to be used. Therefore people were not protected against the risks of receiving inappropriate or unsafe care or treatment as care had not been assessed, planned and delivered in a way that met people's individual needs.

Care plans and risk assessments were not reviewed after incidents. We looked at incident records and saw that an incident had occurred during a car journey. We discussed this with the manager who confirmed no analysis of the incident had occurred and the person's risk assessment had not been updated following the incident. This person's care had not been appropriately assessed to ensure it met the welfare and safety of the person.

Appropriate procedures were not in place for dealing with emergencies that could be reasonably expected to arise from time to time. There were no plans to detail what steps staff should follow to maintain each person's safety in the event of an emergency, where evacuation of the premises may be required.

This is a breach of Regulation 9 of the Regulated Activities Regulations 2010. You can see what action we told the provider to take at the back of this report.

There were insufficient staff available to meet people's needs. One form of restraint used in the service required three members of staff and on one occasion there had only been two members of staff available to complete this restraint. The manager told us in the daytime four to five members of staff were needed to meet people's day time needs. However staff told us, and we identified a day on the staffing rota with the manager where the service had only

three members of staff on duty. This meant that at times the service had been operating with insufficient staff to safeguard the health, safety and welfare of people using the service.

Some staff we spoke with told us they had regularly been working in excess of 40 hours a week. For some staff, on some occasions, they had worked over 70 hours in one week. Records we saw confirmed this. Some staff told us they would choose to work less however there were not enough staff to cover shifts, including cover when staff have time off. There was a lack of contingency planning for staffing to ensure that there were suitably qualified, well rested staff available to cover for shortfalls.

We spoke with the manager about the numbers of staff available to work at the service and they confirmed they were looking to recruit additional staff. On the second day of our inspection one member of staff told us the manager had been able to reduce the hours they had worked that week.

There was not always sufficient staff to maintain accurate records and enable good practice procedures to be followed to help ensure the health, safety and welfare of people using the service. Staff told us they did not have sufficient time to keep accurate records. We saw there were omissions in daily records that included what food people using the service had eaten. The manager told us that there was not always a second member of staff available to sign as a witness to the administration of certain drugs.

These were breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2010. You can see what action we told the provider to take at the back of this report.

We looked at three staff recruitment files to ensure staff employed were suitable to work with people who lived at the service. All three members of staff had started work at the service before Disclosure and Barring Service (DBS) checks had been received. There were also no recruitment records available for a person working in the service on domestic duties on the day of our inspection. This person had access to service users' money and medicines, including controlled drugs. The manager told us another person had arranged for them to work at the service and they were not able to confirm what recruitment checks had been completed to ensure this person was suitable to work with people using the service.

The provider's recruitment policy stated a minimum of two references should be obtained to check a person was of good character before they began work at the service. One member of staff employed had only one reference on file. We discussed this with the manager who told us they had not been able to obtain a second reference. There was also no enquiry into this staff member's health as part of their pre-employment check. Providers are required to check that people employed are physically and mentally fit for that work.

These were breaches of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 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 this report.

One the first day of our inspection appropriate arrangements were not in place to safely manage people's medicines. Some improvements had been made by the second day of our inspection and the manager understood what further improvements were required.

We found staff who were not trained in handling medicines had access to people's medicines, including controlled drugs. Keys for the controlled drugs cupboard had been left within reach of all staff and there was no restriction on access to the cupboard. On the first day of our inspection this cupboard door had been left open. This meant that appropriate arrangements were not in place for the safe storage and handling of medicines.

Some people were prescribed medicines to take 'as and when required.' We found there were no guidelines in place to ensure staff made consistent judgements when administering this type of medicine to people. We saw a box of paracetamol with no prescription label. The manager said it was for one person who had lived at the service since October 2014 and that it had not been added to the person's prescription. This meant people were at risk from not receiving consistent administration of 'as and when required' medicines.

People using the service were not protected from the risks associated with the unsafe use and management of medicines. The manager told us some medicines we saw needed to be disposed of. These were not being stored in a clearly defined area. There was therefore a risk they could be mistaken for current medicines. We found other

medicines had been overstocked. The excess stock had not been disposed of and the pharmacist supplying the medicines had not been advised no further stocks were required. We found creams for people where the labels had deteriorated so we could not read who they had been prescribed for. We also found creams where no date of opening had been recorded so there was no way of knowing if the cream was ready for disposal.

There were gaps in people's medication administration records. The manager confirmed that the medication had been given however an accurate record had not been kept. As appropriate arrangements were not in place for the recording of medicines administration people were at risk of either not taking their prescribed medication or taking too much.

Medicines are required to be stored at certain temperatures to ensure their effectiveness is not compromised. We found there were no records of temperatures to confirm medicines were being kept within an acceptable temperature range.

These were breaches of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities), which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulations 2010. You can see what action we told the provider to take at the back of this report.

Some staff we spoke with told us they were worried about the risks of working at the service. They told us sometimes people who lived there showed behaviours that caused a risk to themselves as well as others. They told us that everyday objects had been thrown at staff before and they were not aware of any risk assessments in place for some of the larger objects in use, such as pool cues. Some staff also told us they felt vulnerable working in some areas of the building where they felt they may not be heard should they need help and needed to shout. Staff told us, and we saw on the day, that staff sent messages to each other on their personal mobile phones when they required assistance. They told us, and we saw that there was no call bell or alarm system in use around the building, including the sleep in room, for staff to use.

The levels of support people required from staff, to reduce risk to themselves and others, were identified in their behaviour support plans. However we found that these did not always reflect staff practice and that different members of the staff team had a different understanding of what support people needed. One member of staff told us no-one in the service required one to one support from staff at all times and other staff members told us of people who received dedicated one to one support.

On the day of our inspection two staff members took three people who used the service out of the home. The support plan for one of the people taken out stated they required two members of staff in the community, the second person's support plan stated they needed 24 hours a day constant staff availability and the third person's support plan stated staff were to be supervised closely. We spoke with one of the members of staff who had accompanied people. They told us they had risk assessed the situation and made the judgment that they had used a safe staff ratio. They stated they had not gone far from the service and would have been able to call the manager if additional staff had been required. We were concerned that these arrangements were not aligned with people's assessed needs and that inconsistent staff practices could cause confusion resulting in increased risk to people who use the service and others.

Requires improvement

Is the service effective?

Our findings

We looked at what Deprivation of Liberty Safeguards (DoLS) had been authorised for people living at the service. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. Since the service opened three people using the service had been subject to physical restraint by staff. The DoLS in place for one person authorised staff to use restrictive physical interventions (RPI) to restrain them. However, for the other two people, their DoLS did not authorise any use of RPI by staff. It had been recorded that one of these people had been restrained once, and the other person had been restrained on four occasions. Without the appropriate DoLS authorisation in place, people were potentially being unlawfully restrained and were not protected from the risks of that restraint being excessive.

The behaviour care plan for one person using the service stated they received 24 hours a day supervision. This level of supervision would require an assessment to be made as to whether this person was being deprived of their liberty. No application for this person to be assessed under the DoLS process had been made. Therefore there was no assessment in place to determine if the level of control this person was subject to was lawful or excessive.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

We saw that staff managed people's money and we asked to see what decision making had been recorded to satisfy the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. We saw a brief checklist of people's mental capacity had been completed and that the manager had indicated these should be reviewed again. We saw no evidence these had been reviewed further. We also saw that where capacity assessment had indicated people did not have capacity, for example in managing their finances, there was no care plan in place for staff to follow.

This is 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. You can see what action we told the provider to take at the back of this report.

The manager told us staff restricted the amount of alcohol some people in the service consumed. This was because the manager was aware these people also took medication. However, the manager had not obtained any professional guidance in order to form an accurate and informed assessment of the risks to these people through a combination of alcohol consumption and their medication. People's ability to consent to this restriction and the principles of the Mental Capacity Act had also not been demonstrated. The manager had therefore failed to ensure that people received effective care, which was reflective of their needs and good practice in relation to care and treatment.

This is a breach of Regulation 9 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. You can see what action we told the provider to take at the back of this report.

Some staff told us they felt the induction period could have prepared them better and they were not sure of the training they had received. We reviewed a copy of the staff training matrix so we could make sure staff had received appropriate training to support the people who used the service. We could see that where staff had not yet received the training identified as required by the manager arrangements had been made to ensure this training would be completed.

We found staff supervision was occurring inconsistently. Staff we spoke with told us they sometimes had supervision. One person told us the supervision they should have had a couple of months ago never happened. Some staff told us they did not feel they were receiving the support they needed and that this was having an effect on their health and wellbeing. Staff administering medicines did not receive checks on their competency. NICE professional guidance states an annual review is recommended to ensure staff administering medicines remain competent. The manager told us they were aiming to provide supervision to staff every two months. Staff supervision records we looked did not confirm this. We saw one staff member had not received supervision for six

Requires improvement

Is the service effective?

months. The manager told us there was no system in place to forward plan dates to ensure staff received supervision every two months. We saw that where some staff had been involved in an appraisal the sections detailing feedback on staff members' performance had not always been completed.

This was a breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 18 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 this report.

Some professionals we spoke with told us the service was difficult to contact by phone. One person said their phone calls and phone messages were often not returned. They told us this was concerning as they supported people with complex needs and they required updates and responses to their requests for information to be dealt with in a timely manner. Another professional also told us there had been some delay in receiving updates on people using the service.

Families we spoke with told us they thought the staff understood their relative's needs. One person told us, "They're really good with them." Another relative said, "I'm really pleased, they are absolutely brilliant." Another family we spoke with told us how the manager had found out details about their relative's condition before they moved into the service. They told us they found this reassuring. Professionals we spoke with told us staff at the service had been keen to understand people's autism and learning disabilities. One person told us that senior staff had attended training sessions to further understand a person's condition.

One person we spoke with told us they enjoyed cooking their meals. Another person told us they enjoyed eating out at cafes. A family member we spoke with told us they often visited at tea time and the food was, "Spot on." Two other family members told us their relative had been eating well since being at the service. Another professional we spoke with told us that the person they supported had experienced a healthy weight gain.

Staff told us the standard of food was good. Some family members told us their relatives could find making choices difficult and so were not given too many choices over food at the service. They told us this strategy worked well for their relatives and the boundaries were part of their care plan. Care plans we reviewed contained people's likes and dislikes and food preferences.

Most families told us they felt their relatives were being supported to maintain good health. One person told us staff had taken their relative to the dentist. During our inspection some people using the service were being supported to go to the gym. Other people told us about other activities they were supported to try that promoted good health including cycling, football and outdoor pursuits.

One family member felt their relative's existing health condition had been getting worse and although they had mentioned it to staff, they were unsure whether anything had been done to investigate it further. One health professional we spoke with also expressed some concern that a person living at the service had missed health check appointments that had been arranged for them. They also told us the service had not arranged for this person to be registered with a local doctor. As a result the professional had arranged this themselves to ensure it was actioned in a timely way.

Requires improvement

Is the service caring?

Our findings

On the day of our inspection we observed appropriate interactions between staff and people using the service. However, during our inspection we found examples of where staff had restrained people without following appropriate guidance and without consideration of the emotional or psychological impact this had on people. There was no evidence to demonstrate that staff had given people the opportunity to discuss these events or offer support after incidents of restraint. Staff had not recognised the distress caused to people by physical restraint and so had not acted in a caring or compassionate manner by trying to minimise the occurrence of such incidences.

We also found staff had not properly considered the impact that other distressing events may have had on people's well-being. For example, one person had told staff they did not feel safe or want to live at the service after an incident. We spoke with staff about this and found staff had not recognised the need to provide on-going support and reassurance to this individual. This meant that staff were not always focused on people's well-being.

Most, but not all families we spoke with told us they were free to visit their relative when they wanted. One family member told us staff brought their relative to visit them every weekend. However, some relatives told us they had experienced some restrictions regarding contact with their family member. One relative told us they understood the reasons for this but another relative had not received any explanation for the reasons behind these restrictions. There was no consideration of how people's important relationships could be supported and maintained.

People who used the service told us they liked the staff who supported them. One family member we spoke with told us, "There's a really good friendly atmosphere." Professionals we spoke with told us they had observed the people they supported getting on well with staff. During our inspection we found staff had fun with people using the service and helped people stay engaged with their interests throughout the day. We observed when one person felt overwhelmed the staff member offered gentle support and understanding.

Staff were knowledgeable on the best way to communicate with people using the service. Staff we spoke with told us that one person had used a communication board to help settle them into the service. Staff told us because communication and understanding had developed well between this person and staff, they no longer needed their communication board as much.

One person we spoke with was happy to show us their room. They told us they cleaned it and kept it tidy themselves and staff would help them with anything they needed. We saw that this person's room reflected their interests and hobbies and was personalised to them. People told us staff listened to them. One person, as well as staff, told us people enjoyed choosing what films to watch in the evening and some people would do different activities, such as play pool.

Most, but not all of the families we spoke with told us they were happy with the way staff helped people using the service present themselves with their appearance. On the day of our inspection people using the service looked smart and comfortable.

Requires improvement

Is the service responsive?

Our findings

We saw people had signed some of their support plans to record staff had discussed care planning with people using the service. One social care professional we spoke with confirmed that the person they supported had been involved in a review of their care. However, some professionals we spoke with told us they had not been informed of incidents that had involved the people they supported. We saw other incidents reported where no review of the person's care plan or risk assessment had been completed. This meant that there was a risk that people would not receive personalised care that was responsive to their needs.

The manager told us no complaints had been received by the service since it had been operating and they had a policy to manage complaints. Some of the incidents we had been made aware of throughout the inspection had not been investigated as complaints and therefore opportunities to respond and learn from experiences had been missed.

We also spoke with the manager about how feedback was requested from people who used the service, staff and other professionals. The manager told us plans to gather this information were being made however this had not yet happened as the service had not been open for a full year.

Some families told us they would be confident in talking to the manager or director about any worries or concerns. However, some people expressed they did not feel they were approachable. Some staff we spoke with told us their suggestions for improvements were not always acknowledged and they did not feel listened to.

People we spoke with told us they enjoyed being able to follow their interests and hobbies. People told us staff understood what they enjoyed doing. One person spoke to us about their interest in sport. They were supported to watch football matches and play football regularly with staff. Another person told us they enjoyed most of the activities they had been supported to do, but not all of them.

Staff and families told us about one person whose confidence had grown since living at the service, for example they had tried and enjoyed new activities that they would not have previously had the confidence to try. The family of this person felt their relative's confidence had grown because of the effort staff had put in to build supportive relationships.

Families told us they were happy that people were being supported to do things they enjoyed. One family member told us, "This is the best I've ever seen him. Since he's gone there he does lots of activities and socialises more." Another person said, "There's been such a change in [my relative], a vast improvement. He's living a normal life." Other families told us they thought things had improved for their relatives as they were now living with other people of a similar age and with similar interests. They also told us they thought staff put a lot of energy into motivating people to be active.

Personal relationships were encouraged and supported. A family member we spoke with told us they had enjoyed going out with their relative and staff to celebrate the birthday of someone who lived at the service. They told us they also went Christmas shopping with those who use the service.

Inadequate

Is the service well-led?

Our findings

At this inspection we found procedures for assessing and monitoring the quality of the service were not effective. The manager had not identified where accidents and incidents at the service had not been reported or responded to appropriately. During our inspection we found an incident that had resulted in an injury to a staff member and an incident between two people using the service. Although the manager was aware of both of these incidents, no action had been taken to learn from these or reduce the risk of reoccurrence. Staff told us they received no proper debrief from the manager on incidents and information from investigations was not analysed. The monitoring of the service was not effective and as a result risks relating to the health, welfare and safety of people using the service and others were not being identified, assessed and managed.

Other incident forms were not completed appropriately. We saw staff had recorded an incident in the daily notes where one person had been held in RPI on two occasions. When we looked for the incident forms only one occasion of RPI had been reported.

This is 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. You can see what action we told the provider to take at the back of this report.

Procedures used to assess the quality of services provided were not effective or were not in place. A stock check of medicines had recorded medicines were stored appropriately when they were not. No audit procedures had been used to identify where medicines had been overstocked or not disposed of appropriately. Recording failures in the controlled drugs book and in the financial records had also not been correctly identified and investigated. The guidance issued to the service to monitor and review the application and use of a specific restraint technique had not been followed and the guidance to follow post incident debriefs had not been followed. This meant people were not protected against the risks of unsafe or inappropriate care or treatment as the quality of services was not being effectively assessed and monitored.

There was no procedure to make sure all relevant staff were updated about incidents when they had occurred. One member of staff we spoke to had returned from a period away and did not know about a recent and significant incident. One professional we spoke with told us that a person they were supporting told them about an incident that had affected them, however the manager had not been made aware of this. Incidents had occurred in the service that should have triggered safeguarding referrals being made to the local safeguarding authority. No safeguarding referrals had been sent. The same incidents would have triggered the requirement to send notifications to the Care Quality Commission. No notifications had been sent to us. Risks relating to the health, welfare and safety of people using the service were not being appropriately identified, assessed and managed.

Policies had not been reviewed as required and were not reflective of the current situation in the service. For example the medication policy referred to a 'trolley' which was not being used in the service and the Deprivation of Liberty Safeguards (DoLS) policy did not reflect the last Supreme Court Judgement.

Service users' money was stored with people's medicines and other general items such as DVD's. The keys to people's money tins had been left in the locks. This area was unsecured during our inspection and was accessible to anyone in the service. We also found important personal documents were not kept securely.

Risks at the service were not always fully identified. Some staff felt there was not enough information contained on risks in people's care plans and risk assessments. The manager showed us that he was currently updating how risks were analysed and recorded for all of the people using the service. We saw that one person's support plan required sharp knives to be locked away. However on the day of the inspection we found that these were not always secure.

Some staff had conditions that may have affected their ability to undertake certain tasks. We did not see any risk assessments completed for staff that took account of their health and the risks to their health when completing certain tasks that could aggravate existing health conditions. The risks to people using the service and the health, welfare and safety of staff members were not being effectively identified, assessed and managed.

Inadequate

Is the service well-led?

During our inspection we observed there was no hand soap in communal toilets. We asked the manager about this and they told us they were looking to find suitable soap dispensers that would be strong enough not to get broken. In the meantime the manager was advising people to wash their hands using the kitchen sink. This was not a suitable arrangement and did not adequately identify, assess and manage the risks of infection being introduced to a kitchen environment.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

People who used the service told us they knew the manager and director and saw them regularly. Families we spoke with also told us that the manager and director were visible and took an active part in the running of the service. However, not all families we spoke with felt the service was run with an open and transparent management style and that at times it felt 'too controlling. One person told us they felt, "Fobbed off and intimidated," when wishing to find out about their relative.

During our inspection we offered reassurance to one person who used the service. They told us a staff member from the management team had told them, "[CQC] have the authority to shut the place down. If you bang things around today, you might be left on the street." Some staff we spoke with told us they felt there was a culture of blame over any incidents where people had displayed behaviour that caused risks to themselves or others. They told us they felt belittled at times as criticism was given in front of other staff and people who lived at the service.

We were concerned that the management of the service was not based on principles of openness and transparency. We spoke with the director about the perceptions from people on their management style. When we returned for the second day of our inspection one member of staff felt the management style had improved.

People were supported to have good links with their local community. One person who lived at the service attended a local college. Other people told us they used the local shops and had local walks around the area. Staff we spoke with demonstrated they were motivated to work with people with learning disabilities. One staff member told us they had been learning Makaton signing themselves. Staff told us they really liked the people they supported.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Appropriate arrangements were not in place to ensure the safe use and management of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Suitable arrangements were not in place to act in accordance with people's consent, or meet with the full requirements of the Mental Capacity Act 2005 where people lacked capacity to consent. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected from unsafe care or treatment as appropriate information and records had not been maintained in relation to the management of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Effective recruitment procedures were not operated to ensure people employed were of good character, were physically and mentally fit for the work. Regulation 21(a)(i)(iii)(b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Suitable arrangements were not in place to ensure staff were appropriately supported in their responsibilities to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23(1)(a)

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe as assessments of people's needs and the planning and delivery of care and treatment did not meet those needs and ensure the welfare and safety of the service user. Appropriate professional advice and guidance was not obtained to form an accurate and informed assessment of people's needs. Regulation 9(1)(a) and (b)(i)(ii)(iii) Procedures were not in place for dealing with emergencies which are reasonably expected to arise. Regulation 9(2).

The enforcement action we took:
We issued a Warning Notice that required compliance by 10 March 2015

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Service users and others were not protected against the risks of inappropriate or unsafe care and treatment as systems were not effective in assessing and monitoring the quality of service and identifying, assessing and managing risks to the health, welfare and safety of service users and others. Regulation 10(1)(a)(b) and (2)(a) and (b)(iv) and (c)(I)

The enforcement action we took:
We issued a Warning Notice that required compliance by 10 March 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

This section is primarily information for the provider

Enforcement actions

People were not safeguarded against the risk of abuse as reasonable steps to identify the possibility of abuse and prevent it before it occurs had not been taken and appropriate responses to abuse had not been taken. Regulation 11(1)(a)(b) and (3)(b)(d)

People were not safeguarded against the risk of abuse as arrangements were not in place to ensure such control or restraint was otherwise excessive. Regulation 11(2)(b).

The enforcement action we took:
We issued a Warning Notice that required compliance by 24 March 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People's health, safety and welfare was not safeguarded as there were not sufficient numbers of staff for carrying on the regulated activity. Regulation 22.

The enforcement action we took:
We issued a Warning Notice that required compliance by 10 March 2015