Lifeways Inclusive Lifestyles Limited

Capesthorne House

Inspection report

Capesthorne Road
Warrington
Cheshire
WA2 9AR

Tel: 01925650006

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14 June 2018
15 June 2018
18 June 2018
09 July 2018

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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**

Summary of findings

Overall summary

This inspection took place on 14, 15, 18 June 2018 and 9 July 2018 in response to concerns received from members of the public, safeguarding authority and commissioners of the service. The service was last inspected on 18 October 2017 and was rated good.

Capesthorne House is an eight bedded 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is set back off a road in the centre of the local community within proximity to local shops and primary school.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The provider applied to the Commission to deregister the home in view of the risks we identified during this inspection. At this inspection we found an extreme level of risk impacting on the people living at the home with a likelihood of the risks continuing at that level due to the provider not mitigating risks effectively enough during this inspection. This meant there was a serious level of risk to a person's life, health or well-being. The Commission are considering undertaking a criminal investigation into the serious incidents which had occurred. You can see what action we told the provider to take at the back of the full version of the report.

This location requires a registered manager to be in post. A registered manager was in post at the time of our inspection. 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.

On this inspection we found there were safeguarding procedures in place but they had not always been followed appropriately. Safeguarding concerns had not been reported to the appropriate authorities.

We found risks to people and others had not been managed effectively. There was an override button above five doors which were in reach of people. This meant that people with a deprivation of liberty safeguard authorisation in place to keep them safe from leaving the premises were put at risk of accessing the community unsupervised, when it was unsafe for them to do so. The provider had known about this but had not acted quickly to mitigate the risk. After we raised our concerns with the provider, they acted by installing a new more secure key system.

Staff told us about the different types of abuse and they understood how to report a safeguarding concern.

However, not all safeguarding concerns which had occurred since the last inspection had been reported to the relevant safeguarding authority.

There was a system in place of recording incidents and accidents however, we found multiple incident forms which had not been analysed. We undertook a random check and found not all incidents had been recorded onto the provider's electronic system. This meant not all incidents were being reported appropriately or analysed for trends or themes. The provider was not aware of all serious incidents which had occurred in the home.

People who were living at Capesthorne House had a support plan and risk assessment screen in place. We found they were either not detailed enough or had not been reviewed every time an incident had occurred. For example, a detailed specific risk assessment had not been devised for one person who self-harmed.

The design of the home and the environment were not suitable for people with highly complex behaviours which were challenging. The garden fence was adjacent to a busy road and residential housing. People's privacy and dignity was not being upheld as onlookers were able to observe people in distress.

The system in place of ensuring all building maintenance repairs were undertaken was not robust enough. There were several repairs which had not being completed in a timely manner. This meant the environment was unkempt and did not uphold people's dignity.

We checked the electronic systems of administering and storing prescribed medications at the location. We found some anomalies where the stock control numbers of prescribed medicines did not correspond with the number of prescribed medicines recorded as administered. This was due to errors where staff had not signed for a prescribed medicine when it was administered.

The staffing levels were not always meeting the needs of the people at the home. This was due to the number of serious incidents which staff were required to respond to. The provider had not ensured everyone living at the home had their one to one or two to one support at all times in accordance with their care plan. We have made a recommendation about staff recruitment. The provider's recruitment systems included a disclosure barring service check. The risk assessment for a previous conviction was not robust.

Staff we spoke with told us about people's care needs. They understood people's individual behaviours but reported they did not always feel safe when dealing with people's behaviours. We found entries in the records of staff being injured during an incident where a person living at the home went into crisis.

People who lived at Capesthorne House had a deprivation of liberty safeguard authorisation in place for care and treatment. We had concerns people's choices were not always being adhered to.

Staff did not always provide people with person centred care. They were aware of people's likes and dislikes. People were supported to go out into their community.

Whilst we observed staff during the inspection treating people with respect and dignity we found examples whereby this was not always consistent.

The governance arrangements of the home were not robust enough. The senior managers had not ensured there was enough oversight of the home to check on the quality and safety of the service. The registered manager was suspended from duties during our inspection pending an investigation.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The system of reviewing and analysing incidents and accidents was ineffective.

Safeguarding concerns were not reported as required to the safeguarding authority.

The building/premises did not ensure people's safety.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act 2005 were not always being followed.

Fluid charts we viewed were evidencing people were not always being supported to drink enough fluids.

Staff were knowledgeable about people but not all were up to date in mandatory training.

Is the service caring?

Requires Improvement

The service was not always caring.

We received concerning information where people's dignity was not always respected.

Staff had an empathetic approach towards people they cared for and were aware of people's choices built into their individual routines.

Staff were aware what comforted people to calm them when distressed.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving person centred care to meet their needs.

Care planning processes were not robust enough to ensure information was up to date and current.

The complaints process was not robust with one complaint which had not been investigated.

Is the service well-led?

Inadequate

The service was not well led.

The system of analysing incidents and reporting all safeguarding concerns was not robust.

The governance and oversight of the management of the home was not effective.

Risks were not being managed at the home by the registered manager and senior managers.

Capesthorne House

Detailed findings

Background to this inspection

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

This responsive inspection was prompted by information of concern we received from the safeguarding authority. This information and subsequent incidents is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the specific incidents. However, the information shared with CQC indicated potential concerns about the management of risk to people's health, safety and wellbeing. The Commission is aware the police were informed and were called to the location to support staff to manage incidents. The Commission have not received all statutory notifications regarding all activities which are reportable at the home including police statutory notifications. This is also subject to a criminal enquiry.

This unannounced urgent responsive inspection took place on 14 June 2018. A full comprehensive inspection was then undertaken on 15 and 18 June 2018 and 9 July 2018.

The inspection team consisted of one adult social care inspector and an expert by experience who visited the home on 14 June 2018 and one adult social care inspector who returned to inspect on 15, 18 June 2018 and 9 July 2018. A member of the Warrington safeguarding team accompanied us on 9 July 2018 in view of a serious incident on 6 July 2018.

An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience expertise was in services for people with autism.

We reviewed all information we held about the home including the CQC intelligence report which indicated there were a higher than average number of accidents and incidents leading to hospital admission/attendance. This indicator of unusually high rates of emergency hospital admissions for this group of conditions may indicate poor risk management systems or prevention of injury programmes at the home and in some cases, could even indicate instances of abuse. Our intelligence report also confirmed

there was a higher than average turnover of staff at this location.

The methods used to gather our evidence, included talking with people using the service and their family members, interviewing staff, pathway tracking {a review of all records}, observation, and review of records. We reviewed four people's support plans/positive behaviour support plans and risk screen assessment documents. We pathway tracked two people living at the home and reviewed the electronic medication administration record on an IPAD. We spoke with three people who lived at the home, three relatives over the telephone and 12 staff including the registered manager, projects manager and operations manager. We also requested a telephone call with the senior managers to escalate our concerns and spoke with the managing director and nominated individual for the home on 18 June 2018. We spoke with commissioners of the service and local authority staff including people's social workers.

Inadequate

Is the service safe?

Our findings

We asked people who were living at the home if they felt safe. One person told us, "This is not my home. Night staff are treating me like [offensive word]." A second person we spoke with said "Staff are nice, safe living here". A third person told us "Very safe".

We also spoke with three family members who all told us they felt their relative was safe. However, one family member went on to tell us about some aspects of the care being delivered that had not ensured their relative was safe from harm.

We were concerned the provider was not keeping people safe who were deprived of their liberty to access the community unsupervised. A tour of the home revealed there were override door release buttons above five internal doors. Staff told us two people living at the home were pressing the override button and accessing the road outside. Staff told us that one person had left the home unsupervised, daily. A staff member told us that on one occasion a person living at the home exited the building by pressing the override button and was found lying down in the road. On another occasion staff told us the person got onto a public bus and the staff member encouraged the person to return to the home. Staff told us they had no mobile phone despite them asking for this to ensure they could contact the home for assistance. We asked the registered manager if they were aware of the issue about the doors being released and staff not having a mobile phone when out in the community. The registered manager told us they were aware. We viewed the electronic workbook notes which is an electronic system of recording information which is then accessible by the provider. This confirmed that the registered manager first brought the issue of the doors to the provider's attention in January 2018. The registered manager confirmed they had not purchased a mobile phone for staff and this was an oversight. The registered manager purchased a mobile phone for staff use and escalated securing the doors immediately during our inspection. These risks had not previously been managed or mitigated in a timely manner to ensure people were safe.

This is a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations (Regulated Activities) 2014.

In view of staff informing us of numerous serious incidents we asked to view the records of all incidents since the last inspection on 18 October 2017. We raised concerns with the registered manager that the serious incidents described by staff could not be found in the incidents file. We did find evidence in daily records which demonstrated that the serious incidents had occurred. There were five incidents recorded in the incidents file since January 2018. The registered manager told us there were numerous incident forms which were stored in boxes which had not yet been reviewed. This meant the registered manager and provider were unaware of all incidents which had occurred at the service. We asked the provider to arrange for all incidents to be reviewed retrospectively which they acted upon. The provider confirmed in their report to us that they reviewed 119 incident forms retrospectively. We cross referenced a sample of incident forms and found they had not been entered onto the provider electronic workbook. This meant the provider had not ensured a robust system for raising their awareness of all incidents or for analysing them as a way of identifying any trends or themes and learning lessons.

This is a further breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations (Regulated Activities) 2014.

We checked if the staffing levels were sufficient in meeting the needs of the people living at the home, including checks of the staffing rotas. We viewed four people's plan of care and found they were all assessed as needing either two staff or one member of staff to support them during the day and night. However, when serious incidents occurred records showed that one person at times required between four and six staff to support them. At other times incidents occurred where people who required one to one needed more than this level of support and staff were being called to assist and support. We were informed of incidents where staff had to respond to keep one person safe from harm leaving another person without their support. This meant people did not receive the right level of care and support to meet their assessed needs and keep them safe. Staff told us they needed more staff at the times when they were dealing with incidents to maintain everyone's safety.

This is a breach of Regulation 18 Staffing of the Health and Social Care Act Regulations (Regulated Activities) 2014.

Support plans and risk screen assessments viewed provided some information about people but they lacked detail. Care records had not been reviewed and updated following a serious incident with information about how staff were best to support the person. This meant staff were not provided with up to date information they needed about how to provide people with a safe level of care. For example, one person's support plan did not provide staff with enough detailed information about how to manage the person's behaviours in public places or how to minimise the risks of them displaying behaviours which were challenging when out in the community. We viewed records which evidenced the person had been accompanied into the community without staff having a detailed support plan/risk assessment and the person had exhibited behaviours which were challenging.

On further inspection of the home we found other risks to people had not been managed. Two staff members told us about them sustaining fractured fingers following an incident involving one person with challenging behaviours. We found the registered manager was aware of the first incident which occurred in December 2017 but not the second incident when staff sustained injuries. We found the person's behaviour management plan had not been reviewed by the provider following the first serious incident in December 2017. We viewed in the records and corroborated it by speaking to the staff members concerned that a second staff member's fingers had been fractured in a similar incident in April 2018. The staff told us the techniques they had been advised to use to manage the person's behaviours was not working effectively. Despite the serious injuries occurring the risk assessment screen and support plan for the person had not been reviewed and updated following each incident. This meant the provider had not done all that is reasonably practicable to mitigate the risk of this same incident reoccurring.

We checked how people were being safeguarded from abuse and if the safeguarding reporting systems were robust to keep people safe. We scrutinised the safeguarding systems and found not all safeguarding concerns had been reported to the safeguarding authority. The retrospective analysis we asked the provider to undertake, of all incidents confirmed there were 13 safeguarding concerns which had not been reported to the safeguarding authority at the time when the incident had occurred. There were several incidents which had not been reviewed by the provider and had not been reported to the safeguarding authority in a timely manner. We received numerous safeguarding concerns prior to the inspection and during the inspection from members of the public all of which we shared with the safeguarding authority.

This is a breach of Regulation 13 Safeguarding Service Users from Abuse and Improper Treatment of the

Health and Social Care Act (Regulated Activities) 2014.

The provider had completed a building risk assessment but it was out of date at the time of our inspection. The premises needed repair and although staff could provide us with confirmation they had requested maintenance repairs to be completed there were a high number of maintenance repairs still outstanding at the time of our inspection.

We observed a boarded glass panel which we were informed by staff had been smashed during an incident whereby one person with behaviours which were challenging had hit the glass and then attempted to cut themselves on the glass fragments. Despite this the registered manager told us they had ordered another pane of glass to replace it. We observed the design of the building was not always safely meeting the needs of the people living at Capesthorne House. The garden area was not secure and there had been incidents where people had ripped wooden fence panels out, climbed over the fence and climbed onto the roof of a smoking shelter. A gated area was also left open other times enabling people to leave the home without their support. We were therefore, concerned the risks the premises posed for people with behaviours which were challenging had not been safely managed by the provider.

This is a breach of Regulation 15 Premises and Equipment of the Health and Social Care Act (Regulated Activities) 2014.

We checked the provider's staff recruitment processes and viewed two staff files. They both contained an application form, two references from previous employers, interview questions and a disclosure and barring service (DBS) check carried out prior to them commencing in their job role. This meant the provider had a system in place for checking on staff criminal background prior to them starting to work with people at the home. We asked to view any risk assessments for any staff with previous convictions. The registered manager confirmed there was one staff member with a previous conviction which we viewed. The risk assessment was not robust enough and did not have robust control measures to protect people living at the home. We discussed this with the registered manager and project manager who were present on the inspection who agreed to ensure the risk assessment was more detailed.

We recommend the provider review their recruitment procedures around managing risk where applicants have a previous conviction.

We observed there were supplies of personal protective equipment for staff use to ensure infection control policies and procedures were adhered to. Domestic staff were seen cleaning the interior floors and surfaces during our inspection. There was a personal emergency evacuation plan (PEEP) for each person at the home and fire checks had been undertaken such as fire doors, fire alarms and fire equipment. The appropriate building safety certificates were available for us to view which were in date.

Inadequate

Is the service effective?

Our findings

Staff were knowledgeable about the positive behaviour support model and approach being used at the home. Positive behaviour support (PBS) is a person-centred approach to support people who display or are at risk of displaying behaviours which challenge. Staff could tell us about the techniques they were being taught by the provider and which were assessed as the most appropriate for each person. However, staff reported to us that these techniques were not always working. This meant despite staff being knowledgeable and trained by the provider they did not always have the confidence in the techniques they used and sometimes found them to be ineffective.

Staff were working towards the Care Certificate which is a nationally agreed set of standards all care workers are required to meet. The records we viewed confirmed eight staff had completed the Care Certificate within the required 12-week period for completion. However, eight staff had not completed the qualification within the 12-week period. Staff completed a five-day induction into their role, including shadow shifts. Agency staff had not always been provided with a detailed enough induction with pertinent information they needed to know about people to keep them safe from harm.

The provider had a training matrix which showed safeguarding training was out of date for six staff members. There was no date recorded for two of the six staff showing when they had last completed safeguarding training. Training for staff in medicine administration was not adequate as 13 staff were highlighted as requiring this training to be compliant with administering medicines. Six staff were highlighted on the matrix as not having up to date training in the Mental Capacity Act 2005. This meant that staff delivering care had not completed the training required of them to effectively meet people's needs and keep them safe.

This is a breach of Regulation 18 Staffing of the Health and Social Care Act (Regulated Activities) 2014.

We checked the assessment records undertaken and reviewed for one person since their admission to the home in March 2018. We found the assessments undertaken by the provider and subsequent support plan and risk screen were not detailed enough. The person had no positive behaviour support plan in place. The assessment of care needs and risks did not identify all the person's behaviours with corresponding detailed risk assessments for staff to be able to deliver holistic and person-centred care. The person's care needs had not been assessed fully by the provider to ensure staff had the knowledge of all aspects of the person's needs. We found another person's behaviours had not been fully assessed.

The National Institute for Care Excellence states "A personalised plan should be based on an assessment of needs, considering the person's strengths, skills, mental and physical impairment, family and social context, and for children and young people their educational context. The plan should cover: any post-diagnostic support that the person and their family and carers need, what interventions, support and timescales are most appropriate for the person; these include clinical interventions and social support, such as support in relation to education, employment or housing, preventative action to address triggers that may provoke behaviour that challenges, any further interventions for identified coexisting conditions. The plan should

also include a risk management plan for people with behaviour that challenges or complex needs." Autism Quality Standard QS51 Published date January 2014. The provider had not ensured they were upholding the principles of best practice. The provider acted and acted immediately to implement more robust assessments.

This is a breach of Regulation 9 Person Centred Care of the Health and Social Care Act (Regulated Activities) 2014.

Staff records confirmed staff had received bimonthly supervisions. The supervision structure in place was for team leaders to supervise care staff and the registered manager to supervise team leaders. A staff member raised concerns during this inspection regarding this supervision structure and that team leaders were not being awarded the time to supervise care staff. We were told by one staff member they had completed an appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We viewed in the records best interest's processes had been followed and mental capacity assessments were being documented for decisions such as smoking. However, we were concerned the basic principles of people making their own choices were not always being implemented. For example, we viewed an incident form whereby one person had asked a staff member if they could stroke the home's cat. They were denied this and this resulted in the person hitting the staff member. We read in the records the person frequently stroked the home's cat.

Each person living at the home had a DoLS authorisation in place for care and treatment. This was because they had been assessed in line with the MCA as lacking capacity to make certain decisions about their safety and wellbeing. We found the provider was not ensuring they were always implementing the conditions of people's DoLS authorisations. We found people had left the home without their support when it was unsafe for them to do so. Staff told us there had been daily occurrences when people had left the home without the right support. Records showed people had exited the building either by pressing the door release above five doors in the home or by climbing over the perimeter of the home. A DoLS showed that one person required one to one support to keep them safe from harm. This meant the provider was not adhering to the conditions within the DOLS authorisations to keep people safe from harm.

There were incidents seen in the records where staff had used physical restraint and on one occasion we found it had taken place in the absence of a physical restraint plan for the person. This meant there had not been a best interests process and plan put in place for the person agreeing when it would be deemed appropriate to consider physical restraint. We were told by a staff member they had been required to sustain a five staff hold on another person on the floor for approximately 20 minutes. The staff member told us restraint was being used all day on and off for the person when they went into crisis. This meant that the provider had not ensured they were always following the principles of the Mental Capacity Act 2005.

This is a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act (Regulated Activities) 2014.

People required support to maintain a healthy balanced diet. We checked one person's fluid balance charts and found there were gaps during the day which indicated they had not been offered regular drinks. Their support plan stated, "I will need staff support to manage what I eat and drink", "Staff need to monitor that I am drinking enough fluids and that I am having squash that I do not make too concentrated as this could be the cause of my recent UTI's (28.10.17). The person had been suffering with urinary tract infections (UTI's) and so we viewed their fluid intake records to check whether they had been offered sufficient fluids to keep them hydrated. Not drinking enough fluids can increase the risk of urinary tract infections.

We viewed three fluid balance charts for one person and found only one of the three had a date which stated 16 June 2018. According to the chart dated 16 June 2018 the person had drank 700 mls of fluid in a 24-hour period. The second chart we viewed had two entries stating 150 mls of coke totalling 300 mls for another 24-hour period. The third chart confirmed the person had 400 mls in another 24-hour period. We viewed another person's fluid charts and found they were not always being completed with a date to effectively monitor the persons fluid intake. One of the person's charts had two entries of 300 mls per entry totalling 600 mls in a 24-hour period.

This is a breach of Regulation 14 Nutrition and Hydration of the Health and Social Care Act (Regulated Activities) 2014.

Each person had a weekly menu planner which we viewed. Staff were supporting people to eat food and we found people's weight charts evidenced they were receiving their food and nutrition.

We found referrals had not always been made on behalf of people to external healthcare professionals to ensure people were receiving all the input they needed. One person's support plan did not contain their treating psychologist's contact details for staff to contact them. Monthly visits had been arranged but staff informed us they ceased in April 2018 and they had requested they be implemented due to a deterioration in the person's behaviours. Healthcare professionals such as Occupational Therapists had not been contacted to undertake sensory processing assessments. We viewed in the records entries when staff had accompanied people to the dentist and to their general practitioner appointments.

The design and decoration within the home needed attention and further assessment to meet people's needs. One person's room had bare white walls and no blind fitted to their window. Another person had a torn piece of material stuck across their bedroom window with Sellotape.

There were incidents where people had ripped fence panels out of the perimeter fence or away from the ground giving them access to the community without the support they needed. The design of the home was not meeting people's care needs and alternatives/adaptations to the building and decoration had not been considered by the provider.

This is a further breach of Regulation 15 Person Centred Care of the Health and Social Care Act (Regulated Activities) 2014.

We checked to see if staff were knowledgeable and had received the appropriate training to understand and meet people's needs. The staff we spoke with had a good understanding of the people they were delivering care to and what people needed. Staff could tell us about people's routines and what they needed at specific times of the day. For example, one staff member told us how important it was for one

person to eat at a specific time of day as part of their routine. They told us if the person's routine was not followed they would become agitated. Routines and ensuring they are adhered to were important for the people living at the home.

Requires Improvement

Is the service caring?

Our findings

Due to the highly complex needs of the people living at the home and difficulties they had in communicating we contacted relatives and made observations about how caring the service was.

One family member raised some concerns about the use of restraint and their relative's dignity not always being upheld. The Commission received concerns from members of the public regarding how people had been treated and these were being investigated at the time of the inspection. We were informed one person enjoyed riding their bicycle around the grounds and that a staff member had taken the person's bicycle off them and rode it. We were told that other staff stood by watching and laughing and that this caused the person to become distressed.

On the first day of our inspection we observed one person stood in front of their bedroom window with no clothes on the top part of their body. The window had no fittings such as blinds which could be used to maintain the person's privacy. The window overlooked a rear car park accessed by members of the public. We were informed of an incident whereby the person had removed their clothing and was seen by a neighbour who's home overlooked the garden. On another occasion staff reported members of the public were taking photographs/filming the person in distress. The provider had not done all that was reasonably practicable to ensure people's privacy and dignity was being protected and upheld at all times.

This is a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act (Regulated Activities) 2014.

We observed people were comfortable in their home surroundings with one person who was lying on the sofa in the lounge with their support worker close by in the same room. Staff understood and responded to people who used nonverbal communication methods. Staff were attentive and respectful towards people. One person said, "staff are nice".

One person we spoke with told us they were given choices in the day. Staff were aware of people's preferred routines including when people like to get up each morning and when they preferred to eat their meals.

Staff were aware of equality, diversity and human rights and were supporting a diverse range of people living at the home. Staff talked to us about their approach which was empathetic and caring.
Staff described to us how they had dealt with serious incidents where people had been in crisis and how they had supported people during times when they became tearful and remorseful about their behaviour. Staff explained how they comforted people who were in distress by providing them with items which helped to relax them.

The provider was aware of advocacy services but had not considered referring one person who we identified did not have advocacy or an appointee at the time of our inspection.

Inadequate

Is the service responsive?

Our findings

We checked care and support plans for people and found they were not always up to date with current relevant information or advice for staff to follow about people's needs and how to keep them safe. Staff told us they did not have enough time to update care plans and were aware that the information contained within them was not always accurate. One person's care plan assessment document completion date 18 June 2018 did not contain any details for the person's General Practitioner (GP).
An assessment document identified that one person had previously self-harmed but we found their care plan did not follow-up on this with details of signs staff needed to look for or how to minimize the risk of further risks. Care plans failed to include important information about how staff were to provide individualised care and support people needed to meet their needs and keep them safe

This is a breach of Regulation 9 Person Centred Care of the Health and Social Care Act (Regulated Activities) 2014.

We checked whether people knew how to raise a compliant. One person said, "I would go to the staff". One relative told us they raised a concern and felt they were listened to.

The provider's statement of purpose stated they provided each person with a service user guide containing a complaints procedure and explaining the process to them at a level each person understands. We did not see personalised complaints procedures within each person's records we viewed.

We viewed the complaints on the registered manager's electronic workbook system and found there had been one complaint logged following a police visit to the home. There had been a complaint made to the police by a member of the public and the police visited the home on 23 March 2018. A member of the public had raised a complaint that they heard a person shouting in the garden of the home in the early morning. There were no further notes regarding this complaint or details of an investigation undertaken.

This is a breach of Regulation 16 Complaints of the Health and Social Care Act (Regulated Activities) 2014.

Capesthorne House does not provide end of life care however, the statement of purpose dated 30 October 2015 stated "Nursing: Capesthorne House does provide nursing care". This was factually incorrect because the service were not registered to provide nursing care.

People were supported by staff to access the local community. Photographs of people visiting a local pet zoo and go karting showed they had been supported to access activities in the local community. Support plans contained information about people's likes, dislikes and preferences and activities they enjoyed.

People were supported to maintain relationships. Family members told us they were able to visit their relative at the home when they wished. Staff were aware of the important relationships people had and told us they supported people as much as possible to maintain them.

Inadequate

Is the service well-led?

Our findings

We asked people about the management of the home. One person told us "The manager is helpful, caring and cares about everyone who works and lives here." The person told us they would be able to speak with the manager if they needed to about something. A family member old us "Yes, we can phone the manager up. He is caring, approachable and helpful."

We checked the governance and oversight of the service and found there had been a high turnover of senior managers within the organisation. We found a high turnover of staff had been highlighted within our own intelligence report. This meant the manager who supervised the registered manager and management of the home had changed. There had also been a high turnover of staff within the service and at the time of our inspection there were a number of staff vacancies, including positions for a cook and a team leader. Despite this the provider had accepted a new admission in March 2018. The registered manager explained they considered that all the above factors contributed to a deterioration in the service.

We found risks across the service which had not been escalated appropriately and mitigated within a timely manner by the registered manager and the provider. The impact of this was that the service had been operating at an unsafe level and if not for this inspection the risks would have not been escalated. For example, the records confirmed the registered manager and provider had been aware since January 2018 of the issue of no door alarm or control measures to prevent people pressing the override button. This gave people access to outside when it was unsafe for them to do so without the appropriate supervision. We found evidence which showed people had frequently accessed the community without the appropriate supervision to keep them safe. The provider had failed to recognise this and mitigate the risk to people's safety until we identified and raised the concerns with them on inspection.

The system in place for analysing incidents and incidents was ineffective. We identified 119 incidents which the provider failed to act upon in a timely way. Of those 119 incidents/accidents there were a number of safeguarding concerns which had not been reported to the safeguarding authority. The registered manager told us they were not aware of daily incidents where one person had accessed the community without the appropriate support they needed to keep them safe. The registered manager also told us they were unaware of serious incidents when staff sustained injuries from people when supporting them in the community. The systems in place failed to identify serious risks to people and others. The provider failed to ensure they had done everything reasonably practicable to mitigate risks to the health and safety of people receiving care and others.

We were informed about a number of safeguarding concerns by the safeguarding authority prior to our inspection. During our inspection we received further safeguarding concerns which were being investigated. Records and discussions held with staff showed that not all safeguarding concerns had been reported to the safeguarding authority. This meant the systems in place to safeguard people from different forms of abuse had not always been acted upon appropriately.

This is a breach of Regulation 17 Governance of the Health and Social Care Act (Regulated Activities) 2014.

Staff were complimentary about the registered manager but considered they needed additional support to manage the service. One staff member told us, "I have a lot of respect for the registered manager, he needs more support" and another staff member told us there was a tense atmosphere amongst the team and they were not always able to approach the registered manager. Three staff members told us they did not feel safe at work due to the seriousness of the incidents which had occurred. Three staff had visited accident and emergency services due to injuries sustained at work. One staff member told us, "I feel I got battered on Saturday", following an incident when one person was in crisis.

Despite serious incidents occurring frequently the provider had not undertaken urgent behaviour management reviews with people to ensure they were doing all that was reasonably practicable to manage behaviours which were challenging. We asked the provider to undertake urgent reviews with everyone living at the home to establish if their needs could be safely met at the home.

We asked the provider to complete a full health and safety audit of the premises in view of the concerns we found on this inspection. We were provided with a copy of the audit which did not highlight how the provider intended to manage the risks posed by the perimeter of the home. There had been several incidents where people at risk had accessed the community unsupervised, by climbing over the fence and pulled wooden boards away from the fence to climb through it. The security of the perimeter including the fence had not been identified on the audit. This meant the provider's auditing systems failed to identify and mitigate all the risks for people living at the home.

This is a further breach of Regulation 17 Governance of the Health and Social Care Act (Regulated Activities) 2014.

The provider is required by law to notify the Commission of specific events occurring at the home. We found numerous incidents and events including when the police had been called by the staff which the Commission had not been notified as required. This is a criminal offence under the Health and Social Care Act 2014.