Independence-Development Ltd

Sinon House Therapeutic Unit

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 May and 14 June 2017, was unannounced and carried out in response to concerns that had been raised following an inspection of the provider's other service. The second inspection was in response to an incident that the provider had alerted us to.

Following the first day of our inspection we sent the registered provider a Letter of Intent (LOI). This is a document which outlines the serious concerns that had been found and requests an action plan to be sent, which detailed the action taken by the registered provider. These included people's documentation, the recording and monitoring of incidents/accidents, the failure to keep people safe, protect them from harm and ensure staff were skilled and competent. The registered provider sent an action plan containing information regarding the changes that had been made to the service being provided to people. Following the second day of our inspection we were satisfied that the serious concerns we raised in the LOI had been actioned.

Sinon House Therapeutic Unit is registered to provide accommodation for young people between the ages of 16-31 who require a high level of therapeutic care and supervision. Support is given to people who have learning disabilities, mental health needs, behaviour that challenges themselves or others and those requiring supervision due to legal cases in court. At the time of our inspection, three people were living at the service.

Sinon House Therapeutic Unit was last inspected in June 2016, when it was rated as Good. On the first day of the inspection we found that risks to some people had not been properly addressed or minimised in a number of areas. These included risks to people's health, safety and well-being from a lack of behavioural management strategies, potential risks of abuse not being assessed and the risk of serious harm had not been effectively monitored. On the second day of our inspection, following the serious concerns we raised with the registered provider, action had been taken to develop a more robust risk assessment methodology. However, the recording of risk was inconsistent.

At the time of our inspection there had not been a registered manager in post for a period of 11 months. A registered manager is a person who is 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.

Systems designed to protect people from the potential risk of abuse and harm had not been effectively operated. High risk behaviours were not monitored to reduce the risk of reoccurrence.

On the first day of our inspection, there were insufficient skilled or trained staff available to meet people's needs. Staff had received most standard training but had not been trained to meet people's complex specialist needs. On the second day of our inspection, following the serious concerns we raised with the

registered provider, action had been taken to ensure increased staffing levels and provide staff training in specific specialist needs.

Recruitment processes were not sufficiently robust to make sure that only suitable staff were employed to work with people.

The principles of the Mental Capacity Act 2005 had not been applied to people living within the service. People's ability to consent to specific decisions about their lives had not been assessed or recorded. There was a lack of knowledge of the action that needed to be taken to assess people's capacity. Mental capacity assessments had not been completed and decisions had not been made in people's best interests.

On the first day of our inspection, one person at high risk of malnutrition was not supported to maintain their nutrition and hydration. Records were not accurate in relation to people's food and fluid intake. On the second day of our inspection, following the serious concerns we raised with the registered provider, action had been taken to ensure monitoring of people's food and fluid intake, and to updated care plans. People were encouraged to eat healthily when making meal choices.

Pre-admission assessments had not been completed to ensure the service and staff were able to meet the persons' needs. Care planning was not person-centred and did not reflect people's individual personalities and preferences. People had an individual activity planner and chose whether to participate in the arranged activity, but were not involved in deciding the activities available to them.

People were encouraged to increase their independent living skills. Staff had supported two people to start work in a local charity shop. People were asked for their feedback about the service; however this was not always acted on.

A system was in place to monitor and respond to complaints that had been made. Incidents that the provider is required to tell us about by law had not been sent to the Care Quality Commission.

Quality assurance systems were not effective. There was inadequate oversight by the registered provider to identify and remedy the issues we found during this inspection. As a result we found a number of breaches of Regulation relating to people's health, safety and well-being.

You can see what action we told the registered provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people had not always been identified or mitigated.

Systems designed to protect people from abuse or harm had not been operated effectively.

There were not enough staff to meet people's needs.

Recruitment practices were not sufficiently robust.

Medicines had been safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was lacking in some areas; which meant they were not fully equipped to carry out their roles effectively.

People's capacity to consent had not been assessed. The principles of the Mental Capacity Act (2005) had not been followed.

People had access to health care but actions had not always been taken to reduce the risk of malnutrition.

Staff felt supported in their role by the unit manager of the service.

Is the service caring?

Good

The service was caring.

Staff were kind and caring. People had their privacy and dignity maintained.

People had not always been involved in the development of the care and support they received.

People were supported to develop their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre-admission assessments had not been completed to determine if the service was suitable, and able to meet the person's needs.

Care planning was not person–centred and did not reflect people's individual personalities.

Reviews of people's care plans had not always taken place to ensure they were receiving the support they required.

Systems were in place to monitor, record and act on any complaints.

Is the service well-led?

Inadequate

The service was not well-led.

A registered manager was not in place and had not been for a period of 11 months.

There had been inadequate oversight by the registered provider to highlight shortfalls in the quality and safety of the service. Quality assurance auditing had been ineffective.

Feedback that had been sought from people had not been acted on.

The provider had not notified the CQC of incidents which caused harm and required medical attention.

Sinon House Therapeutic Unit

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 11 May and 14 June 2017 and was unannounced. The inspection was carried out by two inspectors and an inspection manager. We did not ask the provider to complete a Provider Information Return (PIR), because the inspection was brought forward due to concerns that had been raised following an inspection of the provider's other service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was gathered during the inspection.

Before the inspection, we looked at notifications about important events that had taken place at the service, which the provider is required to tell us by law.

We spoke with the three people living in the service about their experience of using the service. We spoke with one member of staff, the unit manager, the service manager and the registered provider.

We spent time looking at records, policies and procedures, complaints, incident and accident monitoring systems, internal audits and the quality assurance system. We looked at three people's care files, three staff recruitment files, the staff training programme and medicine records.

We asked the provider to send additional information after the inspection visit, including the staff recruitment files, food and fluid monitoring records and updated risk assessments. This was emailed to the inspector.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy and felt safe living in the service, on the second day of the inspection. One person said they felt "very safe" now following the first day of inspection, since the staff team had received training support and guidance from the Children and Adolescent Mental Health Team (CAMHS). Health care professionals working with the service told us they had seen improvements. One said, "We were concerned at the time of your (first) inspection as there was a higher occurrence of self-harming behaviours. Things have improved a lot and we are working with the placement to maintain the support as we've seen improvements."

On the first day of inspection people were not protected against risks and action had not been taken to prevent the potential of harm. Potential risks to peoples' health, safety and welfare that had been identified by health care professionals, had not always been assessed and appropriately managed by the service. These included the risk of malnutrition and dehydration. Sinon House offers a service to people with a high level of need, including behaviour that challenges. This can include behaviour that presents risks to other people living at the service, who may be particularly vulnerable. Records showed that some risks had not been assessed specifically for their impact on other people at the home, and care plans lacked information or guidance on risks and how to ensure that the safety and well-being of all residents was ensured. We shared our concerns with the registered provider who produced a new risk assessment template and provided us with copies of five new risk assessments addressing the areas of concern that we had identified.

On the second day of inspection potential risks to people had been assessed and recorded. Records showed additional risk assessments had been undertaken following a recent incident. However, recording of the analysis of the risk was inconsistent. For example, an assessed risk had been scored as low when the severity and likelihood had been scored more highly. The registered provider agreed that the risk should not have been scored as low, and agreed to reassess the risk. Effective risk assessment and response to risk was not yet embedded.

Incidents and accidents involving people were recorded by staff, and the manager said they investigated incidents and accidents. However, records showed that one person had 14 incidents within a five month period. Although the registered provider had attended a meeting with the local authority and health professionals to review the person's support needs on the first day of our inspection, there was no record at the home of any analysis to identify triggers or themes, and action had not been taken to change care plans or practice to prevent or reduce any further occurrences over that five month period. When we asked the unit manager for evidence of any review or analysis of incidents, they provided us with a hospital admission log which did not contain any information relating to the cause, patterns or review undertaken by the service.

The provider had failed to assess the risks to the health and safety of people and to do all that was practicable to mitigate the risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents involving hospital admissions were being recorded on a hospital admissions/visit log. We asked the unit manager how they looked for any patterns, trends or spikes (an increase) in a person's behaviour and we were told that following an incident the unit manager reads the report and speaks to the person involved on a one to one basis. We raised our concerns with the provider about the lack of systems to monitor and respond to incidents, and on the second day of our inspection records showed incidents and accidents involving people were recorded and monitored by the unit manager.

On the first day of our inspection, we found that there was not enough staff on duty to keep people safe and meet their needs in line with their care plan. Each person's 'individual therapeutic care plan' stated that they received one to one staff support and supervision. However, records showed that there were two members of staff on duty during the day and night to support three people. One person we spoke with told us about an occasion when they felt upset and wanted to go out for a walk to calm down. However, another person had gone out with a member of staff which left only one member of staff with two people. The other person did not want to go out, therefore the person was not able to take the time out of the service they wanted to. Staffing levels had not been assessed by the provider to ensure that it met people's needs. The provider told us that the service was funded for two staff during the day and night, the hours were split depending on people's needs which contradicted people's individual therapeutic care plan's showing they needed one to one support and supervision. Following our initial inspection and the concerns we raised, the registered provider increased the level of staffing to three staff on duty during the day, so that people were receiving the one to one support from staff indicated in their care plans. The provider reported that this was on a short-term basis while they discussed arrangements with the placing authority.

The provider had failed to assess and ensure there were sufficient numbers of staff on duty to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This risk has now been mitigated with the additional staff on duty to ensure people receive one to one support.

The provider had procedures in place for recruiting new staff, but these had not been consistently followed. Recruitment files had been moved from the service to the provider's local office. We requested the complete recruitment files for three members of staff to be sent to us. The three recruitment files did not contain all of the information required under schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Of the three files we checked, two files did not have a full employment history. Gaps in employment had not been explored and recorded by the interviewer. One file contained no application form and another contained no references. Some staff did not have a Disclosure and Barring Service (DBS) background check in place. Although one person's documents included a DBS reference number on their 'employee interview checklist', we could not be sure that people had these checks in place and that staff were checked against the adult and children barring list. DBS background checks check employment histories to help ensure they were safe to work at the service.

The failure to ensure fit and proper persons were employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were maintained and checked to help ensure the safety of people, staff and visitors. Records showed that portable electrical appliances, gas safety checks and the electrical installation were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order.

A fire risk assessment had been completed in July 2016. An action from this assessment was for the service to hold a fire drill as the records showed a drill had not taken place for a period of 12 months. At the time of

our inspection nine months later, records showed that a fire drill had not taken place. During this inspection, a member of staff showed us an entry in the diary which said 'fire drill' but fire records could not confirm that this had taken place and who had taken part.

We recommend the registered provider actions the outstanding actions recorded within their fire risk assessment.

People had a personal emergency evacuation plan (PEEP) located within their 'individual therapeutic care plan'. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. This included a safe route of evacuation and a plan of the building. An individual fire risk assessment had also been recorded for each person living in the service. People's safety in the event of an emergency had been considered and recorded.

Staff spoke about what action they would take if they suspected harm or abuse. This included speaking with the unit manager and contacting the local authority safeguarding team. Staff followed a 'safeguarding' policy and attended training in safeguarding adults and children.

Medicines were managed safely and people received their medicines as prescribed. Systems were in place for the ordering, obtaining, storing and returning of people's medicines. Staff were trained in the administration of medicines and completed an annual competency check with the unit manager. Medicine records were up to date with no gaps showing that medicines had been signed for. Some people had "As and when required" PRN medicines. Guidance was in place for staff to follow which included the dosage, frequency, purpose of administration and any special instructions. We observed one person requesting pain relief, this was actioned and appropriately recorded on the medication administration record (MAR). Regular audits of people's medicines were completed by the unit manager. An annual audit had been completed in March 2017 by a local pharmacist, and no issues were identified.

Requires Improvement

Is the service effective?

Our findings

Staff had not always received the appropriate training and guidance to meet people's specialist and complex needs. Some people living at the service had specific health conditions and behaviour that could challenge themselves or others. On the first day of our inspection, we found that staff did not have the skills, knowledge or confidence to manage these conditions. One person told us that they felt some staff did not understand their complex support needs, and said, "They just talk to me and say don't do it again, it makes me want to do it more."

On the first day of our inspection records showed staff had received training in a range of general subjects such as, equality and diversity, health and safety, Mental Capacity Act (MCA), principles of care and confidentiality, safe administration of medicines and safeguarding. Some had undertaken supplementary courses in a range of subjects including assessing needs, challenging behaviour, consent, nutrition and diet, person centred care, and risk assessment. Records confirmed staff had received the basic training required to meet people's needs. However, one person's needs were not being met by staff as evidenced by the incident reports and comments made by that person regarding staff training and understanding. Some people living at the service had specific health conditions and behaviour that could challenge themselves or others, and staff did not have the skills, knowledge or confidence to manage these effectively. Records showed staff had not received training relating to supporting people who displayed self-injurious behaviour. One person told us that they felt some staff did not understand their complex support needs, and said "they need more training".

We raised our concerns with the registered provider following the first day of our inspection. The provider was required to draft and urgent action plan and inform the Care Quality Commission how they would meet the regulations. The provider submitted information on staff training. On the second day of our inspection, we found that staff had received the training, support and guidance required to meet people's complex care needs from the CAMHS team. One person told us that since staff had received training they felt that this had directly helped them. They said the training had "taught staff how to look after them better", and that now "they know what to do".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some people needed support to make some decisions. People's capacity to make specific decisions had not always been assessed to show what support they might need. For example, one person could not process the consequences to most of their actions and was refusing to wear prescribed glasses. Another person was making high risk decisions around their nutrition and hydration needs: neither of these people had received a capacity assessment.

The providers 'Dignity and Respect' section of the 'Internal Audit of Quality' asked "Have service users who lack capacity had this assessed via MCA/DoLS 1 form?" The answer stated "No. There is no evidence of DoLS/MCA forms in individual forms. If required DoLS/MCA to be put in place when they are over 18 years old." This suggested that the provider did not realise that MCA applies to the 16-17 year olds who used the service. After the inspection the provider sent us MCA assessments for two people living at the service. However, one of the assessments for the preparation of meals/food consumption for a young person recorded that they could not retain or weigh the information but it still recorded that they had capacity to decide which was contradictory. We saw another MCA assessment which had been sent to us that correctly identified that the person lacked capacity, but there was no best interest decision recorded.

Failure to adhere to the Mental Capacity Act (2005) is a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On the second day of inspection records showed MCA assessments had been completed inconsistently. For example, one persons' MCA had answered 'no' to two questions which meant the person did not have capacity.

People were at risk of poor nutrition and hydration as records were not maintained or monitored consistently and clear guidance was not always available to staff. One person, who was at high risk of malnutrition and dehydration, had been assessed by health care professionals and an intervention plan was in place for staff to follow. Their care plan indicated that food intake was to be monitored and recorded by staff, and guidance was in place for action to be taken when intake was below a certain threshold. However, food records showed that on the first day of our inspection and two days prior to that there had been no recorded intake of food or fluid for over 48 hours. This should have resulted in the person going to hospital according to guidance in the person's file. We raised this with the unit manager who was unaware that records indicated no intake over this period. Following further investigation by the unit manager, staff confirmed that the person had eaten. We asked the unit manager if information for staff about the person's support needs around eating was included within the persons 'individual therapeutic care plan' as we could not see it. We were told by the unit manager that it was not included in the plan nor had it been risk assessed. This meant that there was a risk that staff would not provide consistent or appropriate support to the person. Since our inspection the provider had implemented monitoring of people's food and fluid intake, and provided CQC with an updated care plan.

Each person had an individual menu which they were supported to complete on a weekly basis. Staff told us and people confirmed that they were encouraged to eat healthily including fresh fruit and vegetables. One person said, "I can choose what I want to eat." A separate record was kept of how much people had eaten. People's weights were monitored and recorded.

People had access to a range of health care professionals who were involved in their care including the persons' GP, dentist, opticians, social workers, psychologist and psychiatrist. A record was kept of all appointments with any actions or outcomes recorded. On the second day of our inspection people were receiving support from a community nurse regarding sexual health.

Staff told us they felt supported in their role by the unit manager. Systems were in place to ensure staff received supervision with their line manager on a regular basis. These meetings provided opportunities for staff to discuss their performance, development and training needs. Regular staff meetings were held which gave the unit manager and the staff, the opportunity to discuss any concerns or updates there had been in relation to the service.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. Comments included, "Staff are nice and good." Another said, "The staff are alright." A third said, "The staff are nice and they help me." Throughout our inspection we observed positive interactions between people and staff. Despite this, we found evidence that the service was not always Caring.

There was evidence that people were not routinely involved in decisions about their care. In some cases people had signed their individual therapeutic care plans to confirm that these had been agreed with them, but in others there was nothing to confirm that plans, risk assessments and choices had been discussed and agreed. One person told us that they were not aware of their care plan; however they had signed this document. People's individual therapeutic care plans did not contain information about their preferences, likes, dislikes and interests. Instead these were more formal documents highlighting past and historical risks, as well as the goal for the placement. One person had access to an advocate; this is a person who is independent from the provider and the local authority.

We recommend that the provider works with people to include their likes, dislikes and preferences within their plans of care.

People were supported and encouraged to develop and increase their independent living skills. For example, budgeting, cleaning and skills such as food shopping. The purpose of the service was to offer 'A semi-independence training programme for young people.' One person said, "The staff like us to be independent, washing up and cleaning my room." People had been supported by staff to set goals for themselves for the forthcoming month during their key worker meetings. A key worker is a set member of staff who has the responsibility for updating records relating to the person. One person's goal was to increase their independence and find a paid job. Staff had supported this person to find a voluntary job at a local charity shop. People living at the service shared space and facilities; however, staff were still able to support people with their independent living skills.

People were supported to maintain contact with their loved ones where appropriate. One person said, "I speak to (loved one) once a week and get an update on the family. Staff from the other unit took me to see my (loved one)."

People told us that the staff respected their privacy and dignity. One person said, "Staff respect my privacy and knock on the door, we get our own privacy." Staff explained how they protected peoples' privacy by "knocking on peoples' door and waiting for an answer before entering." We saw this happening during our inspection.

People were supported to take part in house meetings. These meetings gave people the opportunity to discuss any area for improvement within the service and address any issues or concerns people had. For example, the meeting minutes from 4 March 2017 showed that people had requested to stay up later than 22.30pm, it was agreed that people were able to stay up until 23.00 at the weekends. Staff had also spoken

to people about the importance of healthy eating and taking part in activities.

Requires Improvement

Is the service responsive?

Our findings

People told us they enjoyed living at the service and got on with the other people they lived with. One person said, "It's one of the best places I have been." Another said, "It's good here, the young people are understanding." Despite this, we found evidence that the service was not always Responsive.

Pre-admission assessments had not been completed by the provider prior to people's admissions, which meant that people could move into the service without the provider or staff having sufficient information about them to be able to meet their care needs or identify potential risks to other people. When asked about the potential risks to some of the people living within the service that had not been assessed, the provider told us that one person had required an emergency bed. He said, "We looked at the referral form and said we could accept (name). In best practice we would have liked to have a pre-assessment, but the reality is, it's not always available." We asked the provider about another person who had very complex support needs and a high level of risk to themselves. The provider said, "The local authority offered the placement and wanted to discharge (name) within a week. We didn't need to do one (pre-admission assessment)." Without a thorough assessment of people's needs the provider could not be sure they could meet those needs and that anyone moving in would be compatible with other people.

Care planning was not person-centred. There was no information within people's care files to show anything about their individual personalities or the things and people who were important to them. People had not always been involved in the development of their care plan by advising staff how and when they would like their care and support provided. There were limited details about people's preferred routines and how staff should support them with these. Records showed a lack of guidance for staff to support people during high times of anxiety for them. One person told us they felt that the staff did not always know how to support them. One person when asked about the care plan said, "I don't know what that is," This person had not been involved in the development of their individual therapeutic care plan; however, they had signed the document.

People' plans had not always been regularly reviewed with them or the health care professionals involved. We found guidance on one person's care records that the provider and unit manager said was no longer relevant. Another person's plans had been reviewed on a three monthly basis. The reviews were inconsistent which led to staff following guidance which had not been reviewed or amended as required. For example, the nutrition and hydration information had not been updated.

We were told by one person that the activities were not person centred, they didn't have any input into the weekly planner and they were bored most of the time. Another person told us they "don't do much activity." People had a weekly timetable in place with activities within the service and out in the local community. Records showed that when people were offered a choice they had chosen to stay within the service playing on games consoles. It was not clear whether people were given ownership over their activity timetable, and whether people were encouraged to engage in activities.

The failure to provide person-centred care planning and support is a breach of Regulation 9 (1)(a)(b) Of the

Health and Social Care Act 2008 (Regulated Activities) 2014.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The unit manager recorded all complaints in a complaints log and there had been four complaints recorded in 2017. There was a complaints policy that set out the procedure for responding to complaints and timeframes for replying to complainants. All complaints had been dealt with in line with the registered provider's complaints policy. We reviewed a sample of complaints and found that the unit manager had ensured that learning was put in place from any shortfalls in service and issues were resolved. There was a complaints file with a policy and procedure in place, last reviewed on 20/01/2017. People told us they knew how to make a complaint and had done recently.

Inadequate

Is the service well-led?

Our findings

People told us they knew who the unit manager and the registered provider were. One person said, "I can sometimes talk to the manager. (Registered provider) I've seen about four times, he gives me my PIP money." Another person told us the registered provider had helped them save for a games console, they wanted. We observed a positive and open culture between people, staff and the unit manager. Despite this, we found evidence that the service was not always Well-led.

The previous registered manager had left the service in February 2016. The service had a unit manager in place who at the previous inspection in June 2016, who informed us they had applied to become the registered manager. Therefore the service has been without a registered manager for 11 months. The registered provider is required to have a registered manager employed at the service as a condition of their registration. We spoke with the registered provider about the lack of a registered manager at the service and were told that the unit manager was in the process of arranging documents to submit an application to register. CQC had not yet not received an application for registration. This constitutes a breach of the registered provider's condition of registration.

Systems were in place to monitor the quality of the service being provided to people, however these had not always been effective at highlighting the concerns that we found during this inspection. We saw an audit file that contained an 'Internal Audit of Quality' which had been conducted every six months. The last audit had been completed on 23/02/17 by the service manager. The audit highlighted actions that required completing and then recorded when these had been completed. The audit highlighted a need to create a training file, supervision file and a monthly staff check form, which we saw had been implemented. However, the audit had significant gaps and inaccuracies. For example, it stated that pre-admission assessments were in place and complete, yet we requested these and found that none had been completed. The audit of people's files did not highlight the issue that care plans did not provide clear guidance to staff on people's care needs and were not person centred. For example, they did not contain information on how best to support people during times of high anxiety, and one person had not been involved in their care plan despite being able to and identifying that staff did not always know how to support them. The overall governance and quality assurance system had failed to identify the shortfalls that were found during the inspection.

Annual surveys had been completed by people and health care professionals. Two surveys completed by people using the service rated the cleanliness of the service as 'poor'. A health care professional's survey completed in June 2016 rated the cleanliness as average. There was no action plan from the responses to the surveys to improve how clean the service was. Feedback was actively sought however, this was not acted on or used to drive improvement.

The provider had failed to operate effective quality auditing systems. This is a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regular checks of the quality and safety of the service had been completed by the unit manager but these

were not always effective in identifying shortfalls and ensuring improvements. There was a monthly health and safety risk assessment that had been completed. Daily checks were completed and covered: medicines, daily observations, progress reports, housekeeping, incidents, petty cash, living allowances, and environment. However, these checks had not identified that a person was at high risk of malnutrition and dehydration.

During the first day of our inspection we read about a number of incidents in which the person required medical attention and suffered harm. Such incidents must be notified to the CQC without delay, but the provider had failed to do so. 14 incidents had taken place of which we had been notified of only two. The registered provider had not notified us of all events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. There were incidents that we were not aware of and had only been made aware of subsequently to our site visit. We schedule inspections against information we receive, so had we been made aware of incidents we may have inspected the service sooner.

The failure to notify the CQC is a breach of Regulation 18 (1) (2) (d) of the Care Quality Commission (Registration) Regulations 2009.

Staff told us they understood their role and responsibility. Each member of staff was given a job description which outlined the requirements for their role. Staff were given additional responsibilities by the manager such as the fire alarm checks. The manager held regular staff meetings; these meetings gave staff the opportunity to give their views about the service and to suggest any improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify the CQC is a breach of Regulation 18 (1) (2) (d) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to provide person-centred care planning and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to adhere to the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to to assess the risks to the health and safety of people and to do all that was practicable to mitigate the risks