Richmond Fellowship(The)

Windsor Road Mental Nursing Home

Inspection report

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Date of inspection visit: 03, 04, 08, 09 and 16 June 2015
Date of publication: 10/08/2015

Ratings

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

Overall summary

This inspection took place across five dates 03, 04, 08, 09 and 16 June 2015 and was unannounced.

The last inspection of Windsor Road Mental Nursing Home was 15 May 2013 and the service was found to be fully compliant against the five outcomes we looked at.

Windsor Road Mental Nursing Home provides care and accommodation for up to eleven adults who have enduring mental health needs. The home is a purpose built establishment with facilities on two levels, the upper floor being served by a passenger lift. All accommodation is offered on a single room basis including self contained bedsit type facilities with private kitchen areas. The home is located on a quiet road in Lytham St Anne's close to local amenities and bus routes.

Summary of findings

The registered manager was available throughout our visits and received feedback during and at the end of the 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.

We engaged with all people who lived at the service, we received valuable feedback about how people perceived the standard of care and support provided by the service. People told us about varying experiences often highlighting inconsistencies in approach and support by certain members of the care team.

People told us that they felt safe, however we found that safeguarding principles had not always been adhered to. We found significant incidents were not always adequately reported or acted upon.

We found that people were not always protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk. This meant that people were placed at significant risk of harm and neglect. We communicated our concerns to associated commissioning teams and ensured that the standard of risk management at the service was addressed by the provider before leaving the site on all days of inspection.

We found that people's safety was compromised in a number of ways. The service failed to protect people against the risk of fire and environmental risks. We found people who live at the service smoked in their bedrooms however safety standards were not always adequate and this placed people at significant risk.

We found that the service was not responsive to people's individual risks. Failure to adequately assess, report and monitor people's behaviour, incidents or issues, meant that incidents reoccurred or led to potential serious consequences. For example one person was known to be at risk of self-neglect, and we found that the service had not adequately monitored this person's wellbeing or maintained effective communication with the community mental health team. This had significant implications on the person's individual wellbeing and living environment.

We looked at the way medicines are managed and found substantial failures. We found gaps in medicine records and significant omissions in the administration of medicines which led to multiple safeguarding alerts that we asked the manager to raise with the local authority.

People told us that they seldom received support around their recovery and felt that there was a divide between the staff team, some staff wanted to help them recover whilst others made no attempt to talk or interact with them.

The provider told us that Richmond Fellowship adopts an approach that focuses on people's recovery from mental distress, recovery from experiences of social exclusion and the recovery of individual potential and choice.

We observed minimal interactions between staff and people who live at Windsor Road.

The principles of the Mental Capacity Act 2005 (MCA) had not been embedded into practice and we identified concerns relating to how people's valid consent had been obtained.

We found care plans had been completed with a good standard of person centred detail, however new concerns and incidents were not always recorded.

We found insufficient evidence of staff training and development. Staff told us that they felt supported by the team leaders however they felt that they had not received the appropriate training to be able to provide the required standard of specialised care for people living at the service with complex and enduring mental health needs.

We found that people's dignity was not always considered; people with deteriorating mental health needs were not always considered in a person centred way.

We observed people leading an independent life style. People had access to a modernised kitchen area and we observed people cooking which enabled them to remain self sufficient. People came and went from the service at will and accessed the local community.

Summary of findings

We asked people if they would like to engage with employment and voluntary initiatives and many expressed an interest. We found that the service was not effective in encouraging and enabling people to engage community activities available.

We did not find evidence of robust management systems at the service and the quality assurance systems were not effective. This placed people at risk of avoidable harm.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have deemed that the overall rating for this service is inadequate.

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we have introduced special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration. Services rated as inadequate overall will be placed straight into special measures.

You can see what action we have taken at the end of this 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.

The systems in place to identify the possibility of risk and to prevent harm were inappropriate and ineffective.

The processes in place to ensure that people received their medicines as prescribed were not robust and placed people at risk of harm.

People were not safeguarded against the risk of neglect and avoidable harm.

Staffing levels did not support effective recovery provision for people living with enduring mental health needs.

Inadequate

Is the service effective?
The service was not effective.

The principles of the Mental Capacity Act 2005 were not put into practice. Staff had not been trained in these principles and had poor understanding of how to implement these principles.

Staff training was ineffective in ensuring that staff were competent and had sufficient skills to meet the needs of people they cared for.

Inadequate

Is the service caring?
The service was not caring.

People were not treated with dignity and respect.

People were not always approached by staff in a caring way and positive relationships were not consistently promoted by staff.

Inadequate

Is the service responsive?
The service was not responsive.

The processes in place to make sure people's health and social care needs were properly assessed and planned were inappropriate and ineffective.

The service failed to respond to peoples changing needs by ensuring amended plans of care were put in place.

Liaison with other health care professionals was poor.

Inadequate

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

The processes in place to make sure that the quality of service was assessed and monitored to ensure people received safe and appropriate care were not robust and were ineffective.

Inadequate

Summary of findings

People told us that there was a divide within the staff team which had a negative impact on people receiving care and support.

We found a lack of information sharing at the service between clinical and management staff, this had significant implications on risk management.

Windsor Road Mental Nursing 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 across five dates 03, 04, 08, 09 and 16 June 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. 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 had personal experience of living with mental health illness.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from community professionals, such as complex case managers, the local Commissioning Group and mental health teams. We received three responses. Comments about this service varied.

The day before inspection we received information of concern that we have communicated to the local authority safeguarding team for investigation. We used the information from this concern to focus on some specific areas during this inspection.

There were ten people living at Windsor Road Mental Nursing Home. We spoke with all the people who lived at the service, one relative, five assistant support workers, one domestic, three registered nurses, two team leaders, the registered manager, the regional manager and the assistant operations director.

We looked at four people's care records, staff duty rosters, three recruitment files, training records, management audits, medication records and quality assurance documents.

Inadequate

Is the service safe?

Our findings

We spoke with all people who lived at the service and received mixed feedback regarding how people were protected against harm. People told us "I feel safe here, I reported when I was being bullied". "Staffing is ok, not many around though". "Yes I feel safe". "Things have been hard, some staff want to help you but others think we are lazy". And: "I sometimes feel scared of what I might do, some staff I can ask but others just don't want to hear it".

We spoke with a relative who told us: "I have raised my complaints, I now feel things have settled down but there is still a divide in the staff team which affects the people living here".

We looked at how the service protected people from bullying, harassment, avoidable harm and abuse that may breach their human rights. We found ineffective systems for safeguarding people who live at the service and we asked the manager to raise nine safeguarding alerts during the inspection following identification of incidents which led to avoidable neglect, potential harm and errors in medicine administration.

For example we looked at daily care records and incident records; we found that a person living at the service had previously caused an incident that put themselves and others at risk. The incident was not risk assessed and the service did not initiate safeguarding procedures to ensure that preventative measures were put into place. A second incident was then reported; we felt that if sufficient precautions had been considered at the time of the first incident this may have prevented further instances that placed the person and others at risk of harm and injury.

We looked at training records and found gaps in safeguarding training. The training matrix showed that eight out of nineteen employed staff members had received safeguarding training in the past three years.

We spoke with staff and asked them if they felt confident to raise concerns. A registered nurse informed us: "Yes I feel confident, but I think it is not always clear what is or what is not a safeguarding issue".

We found that the registered manager had failed to raise safeguarding alerts for several incidents. For example one person took an overdose of a prescribed controlled medicine. Despite incident reporting by staff members the manager did not inform or involve any external mental health professionals, and the safe guarding team were not notified. The Commission was also not notified in line with regulation.

This constituted to a breach of Regulation 13 (1) (2) (3) and (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a divide throughout the staff team; some staff enjoyed their role as assistant support workers and embraced a recovery theory. This enabled people to deal with the mental health issues and move on with their lives. Others felt that their role was not defined and one assistant support worker told us: " I am not sure what we should do. If we try to engage with the residents other staff tell us that we are not here to sit around talking".

We looked at how the service managed risks to individuals so that people were protected and their freedom supported and respected.

We looked at care records and found that a comprehensive pre-admission assessment was completed before people were accepted for recovery placement at the service, risk management and identified risks were clearly recorded within support plans to evidence how the person would be protected and enabled to maintain their independence.

We found that historical risk was well documented; however the service did not adequately update risk assessments or implement risk management plans when a person's needs had changed or a new incident had occurred. For example one person was admitted to the service for a period of leave from a secure mental health unit; during the leave period the person breached terms of the Section 17 leave agreement under the Mental Health Act 1983 placing themselves at risk. We looked at the person's related risk assessment plans and found that they had not been updated; the person came on a second period of agreed leave and again breached agreements made.

Risk management at the service was found to be inadequate.

This amounted to a breach of Regulation 12 (1) (2) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We looked at how the service provided a safe environment for people. We found significant environmental concerns in three bedrooms which placed people living at the service at significant risk of deterioration in their health and wellbeing.

We looked at ten people's bedrooms and found inadequate standards of cleanliness and risk to individuals health and safety in seven of the bedrooms viewed.

We raised our concerns on day one of the inspection and also communicated with the local fire department who agreed to undertake a comprehensive fire inspection at the service.

The service had failed to adequately risk assess bedroom safety and despite weekly bedroom water temperature checks being undertaken by staff, failure to escalate the risks demonstrated a negative culture within the service with reference to acknowledging, reporting and acting upon risk.

We saw water/legionella checks were completed and recorded on a monthly basis. Temperature checks had been recorded during May and June 2015 in various rooms. On both occasions, temperatures exceeded the limits suggested as `safe` but no further action had been taken. We did not see an action plan to address the concern. This could have a serious impact on residents and staff who were at risk of possible scalding and or burns.

This amounted to a breach of Regulation 15 (1) (a) (c) (e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not observe sufficient staff engagement with people to enable a therapeutic environment. We looked at staffing rotas and found that the service provided sufficient numbers of staff in accordance with their expected staffing ratios. However when we asked the registered manager how staffing levels were determined it was confirmed that dependency levels were not formally assessed.

The registered manager told us about recruitment difficulties for registered nurses. We looked at duty rotas and found that a high number of shifts were covered by 'casual' workers. The team leader explained that the lack of staff continuity had a significant negative impact on clinical care and this led to the escalation of people's deteriorating mental health needs. The manager agreed that the staffing levels did not appear to be enabling recovery work at the service.

This amounted to a breach of Regulation 18 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had effective recruitment policies and procedures in place which we saw in operation during our inspection. We reviewed four staff files and found that pre-employment checks had been carried out. We found completed application forms, Disclosure and Barring (DBS) clearances, references and identification checks were in place. Staff we spoke with confirmed that they had attended a formal interview and did not begin work until appropriate references and employment clearances were obtained.

We looked at medicine management systems at the service. We found that medicine management systems were not robust, placing people at risk of not receiving their medicines as prescribed.

We found that medicines were not sufficiently recorded on receipt. Hand written medicine records were not accurate and when medicines were destroyed, a record was not always maintained.

We found several administration errors had not been adequately addressed and the registered manager had failed to escalate known medicine errors to the local authority safeguarding team. We looked at people's care records when administration errors were recorded and we were unable to locate evidence of referral to medical practitioners for guidance.

We found significant gaps in the recording of medicines, for example one person living at the service had not received their prescribed treatment for a total of five days. The person confirmed that this had a negative effect on their physical wellbeing and caused them to feel unwell for the previous two days.

Another person had not been consistently receiving their anti-psychotic treatment and the team leader explained that casual staff did not always encourage the person to take the prescribed treatments. It was agreed with the registered manager that this the person's mental health was deteriorating.

Inadequate

Is the service safe?

We looked at how the service managed controlled medicines. We found significant discrepancies in one controlled medicine and record keeping was not robust. Another controlled medicine had been administered a day late; no record of why this happened was available.

We looked at medicine stock auditing and found that the staff responsible for undertaking checks had not always counted stock and had continued following what had been previously recorded. This meant that stock balances at the service were not accurate. This meant that any audits were very difficult, and almost impossible to complete.

We observed medicine administration with consent from people who live at the service. We found that people were supported by a staged programme to move towards self administration. Safe administration was observed and people were provided with effective support and guidance about their medicines by the registered nurse.

We looked at staff training for medicine management and administration competency assessments. We found that only four out of nineteen staff have received training; no competency assessments had been undertaken and unqualified assistant support workers were asked to verify and sign when controlled medicines were being administered.

This amounted to a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We asked people if they received effective care, which is carried out in accordance with their preferences and consent. People told us "Staff include me in reviews, they will tell me if I am improving or deteriorating". "I don't go without, I know I can ask the staff". And: "There are some staff here, especially the team leaders who are exceptional and seem to want to help us get better but it is the staff who think the old way that holds this place back".

A relative expressed that they saw a lack of support around mental health recovery; they explained: "At times when (name) is really ill, if I wasn't around I don't think (name) would make it through the day, sometimes they forget (name) is a person".

We looked at care records for four people who live at the service. We found that records did not detail how the service worked in line with best practice around mental health recovery. We asked to see information about the recovery model being followed and it was evident that this information was not easily accessed. People who live at the service should have access to important information which would enable their recovery.

We looked at the training matrix and found significant gaps in training for all staff. We asked the manager on a number of occasions for any up to date information around staff training and this was not provided. We found that staff had not received training that was outlined in the provider's policies and procedures. For example training such as safeguarding of vulnerable adults, fire safety, moving and handling and health and safety.

We asked staff if they felt they had received adequate standards of training and we were informed that they had started eLearning training. However many staff felt they had not been trained in areas which would help them understand and support people living at the service with complex and enduring mental illness.

We asked the manager if staff had been trained in understanding behaviours that challenged, break away techniques or de-escalation of behaviours that challenged. The manager explained that this type of training would be of benefit however had not been provided or scheduled.

The lack of adequate training constituted to a breach of Regulation 18 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at supervision and appraisal records and found a good standard of recording. Staff told us that they were provided supervision on a regular basis and found team leaders to be supportive.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We found that the service had not provided training to enable staff understanding of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. We asked staff if they understood the main principles of the Act and they told us they did not.

We looked at care records and found that people who use the service were asked to sign consent records; for example to consent to self administration of medicines and a 'license agreement for their flat tenancy'. We asked the registered manager to show us how the person's capacity had been considered prior to asking for consent. This information was not available.

The Mental Capacity Act 2005 Code of Practice stipulates:

'There are a number of reasons why people may question a person's capacity to make a specific decision:

- The person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision.
- Somebody else says they are concerned about the person's capacity, or
- The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.'

Inadequate

Is the service effective?

This failure to follow the code of practice amounted to a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they were supported to maintain a healthy diet. People told us "I shop on line at Asda, I can choose my own ready meals", "I am allowed to chose my own food", "some staff will help me cook, others wont so I will get a ready meal" and "I have been supported to attend slimming world, it has done me the world of good".

We observed people using the kitchen area independently. An assistant support worker explained that she had started a cooking class twice per week and it was the first session to be held. We observed a number of people engage with the activity.

We looked at care records and found that people were supported to attend scheduled appointments with health and social care professionals. We were informed that the quality of information communicated to mental health care co-ordinators was variable and dependent on the nurse in charge. The team leader was concerned that casual workers were not always pro-active in sharing information or providing concise reports following Care Plan Approach (CPA) reviews.

We looked at care records for one person and found that the service had failed to escalate known behaviours that represented deterioration in the person's mental health and wellbeing. This led to the person experiencing a relapse in their mental health condition that could have been addressed earlier if this information had been acknowledged and shared with the relevant professionals.

This amounted to a breach of Regulation 9 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

We asked people who lived at the service if they felt 'cared' for. People told us: "Staff are kind, they push me to help improve my independence". "Staff listen and appreciate me". And "I am allowed to see my family and friends".

We also received comments from people that some of the staff team were: "Not approachable". "Don't want to help". People also told us that they feel a: "Rift in the staff team". And: "Staff argue all of the time".

The registered manager explained that in recent months there had been on going issues between the care team. She was aware people who live at the service have been exposed to these issues. The problem was being investigated. We noticed that this had a negative impact on relationship building and one person living at the service explained that they are "ignored" by some of the assistant support workers, so they had "stopped asking them for support".

Staff engagement with people was poor and infrequent, and did not enable a therapeutic environment.

We observed interactions between staff and people who lived at the service throughout the five days of inspection. The communal areas were used frequently however we observed minimal interaction from staff. We saw staff walked past people and say "hello" however staff seldom sat with people who lived at the service and did not fully engage with them.

People living at the service informed us: "Staff stay in the office". "Some staff make an effort, many don't". And: "We are left to get on with life". However, one person said: "The staff here are great, they help me and motivate me".

We asked the registered nurse which recovery model the service followed. The nurse was unable to inform us and referred us to the manager. We asked people who live at the service which recovery model they were working towards and one person told us "what model, we don't recover here". The Richmond Fellowship 'believes that recovery is a journey, and is different for each person. While there is no single definition of recovery, the achievement of the best possible quality of life for each individual lies at the heart of this journey'. We did not find that this belief had been embedded at the service.

An assistant support worker explained "everyone who lives here calls this place fairy land, there is no structure, no push to recover and people think it is great when they can spend all day in bed".

When staff did engage with people they were seen to be pleasant. However the staff interacting were not meaningful, and concentrated on information sharing and pleasantries such as, "how are you" then failed to fully engage with the person.

We looked at care records and found that people were invited to be involved in the care planning process.

We asked to see records of service user meetings and found that meetings had not been held frequently in 2015. The last meeting recorded was 20 March 2015. Four service users attended. The care home was being refurbished and service users were asked for their opinions in relation to colour schemes and furniture items. The minutes we saw showed service users had been fully involved during the meeting. Two service users asked for garden furniture and a barbecue and we were told by the manager these requests had been met.

The manager told us that `service user meetings were not held as often as they should be` and was an area that needed addressing.

We found that people's dignity was not always considered, and that people with deteriorating mental health needs were not always considered in a person centred way. For example we found that one person had not been adequately supported to maintain their living standards, this led to significant risks associated with the person's bedroom environment and consequently when intervention was required the person was not willing to engage. This had a detrimental impact on their wellbeing.

This amounted to a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had policies and procedures that covered areas such as confidentiality, privacy and dignity.

We were unable to find information that would facilitate people's ability to access advocacy services. People who used the service told us that they are aware of advocacy

Inadequate

Is the service caring?

services and would ask staff to help them access this type of service when required. It would be beneficial for people living at the service to be able to freely access this type of information.

Inadequate

Is the service responsive?

Our findings

We looked at the care files for four people who lived at the service and found that a good standard of person centred care planning was implemented upon admission. Pre-admission detail was to a high standard.

However in all records viewed we found instances when the service had failed to appropriately respond to the person's change in needs or manage risks associated with their mental health needs.

We found that the registered person has not protected people against the risk of unsafe care or treatment, because care planning and assessment processes were not always sufficiently person centred and potential risk had not always been managed well.

For example one person had been experiencing a relapse in their mental health and wellbeing for a four week period of time. Staff had recorded changes in the person's behaviour and incidents such as an arrest and detention for a criminal matter. However staff failed to effectively communicate these significant changes and incidents to the key mental health worker involved in the person's life. We found this lack of responsiveness contributed to the person's deterioration and prevented essential interventions to take place.

We looked at another care file for a person recently admitted to the service and found a good standard of pre-admission assessment detail. However the service had failed to assess the person's needs and no amendments had been made to the care plans and risk assessments during the person's leave visits or following admission. This was despite significant incidents being recorded in daily reports during the period of leave.

This amounted to a breach of Regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people leading an independent life style. People had access to a modernised kitchen area and enjoyed cooking in order to remain self sufficient. People came and went from the service at will and accessed the local community.

We asked people if they would like to engage with employment and voluntary initiatives and many expressed an interest. We found that the service was not always effective in encouraging people to access community activities. The manager told us that she wanted to develop social inclusion and had planned to support people to attend a training course. The course concentrated on `Peer Support` and included themes related to skills recognition, communication and assertiveness, wellbeing and the art of positive thinking.

We looked at care records for a person who attended dialectical behaviour therapy (DBT) on a weekly basis. DBT is a therapy designed to help people change patterns of behaviour that are not helpful, such as self-harm, suicidal thinking, and substance abuse. We found that care planning had been completed with the person around their therapy.

We looked at the complaints policy and procedure and saw it included contact details for other agencies, including the local ombudsman. The registered manager told us that since 2013, complaints were recorded on an internal computerised system. The last complaint recorded was in January 2015 which had been handled appropriately and in line with the provider`s policy.

People who live at the service told us that when they were admitted they were given a handbook which contained details of the complaints procedure. New employees were also made aware of the procedure during their individual inductions. Staff and people who live at the service told us they would be happy to talk to the manager or one of the team leaders if they had any problems or concerns.

A relative told us that they have previously complained and felt satisfied with the manager's response.

Inadequate

Is the service well-led?

Our findings

We found that the service had systems in place to monitor the delivery of care, however the systems had not been implemented by the registered manager and quality assurance had not been adequately considered . During the inspection we identified failings in a number of areas. These included person centred care, medicine management, premises safety and managing risk to people. These issues had not been sufficiently identified or managed by the registered manager prior to our visit which showed that there was a lack of robust quality assurance systems in place.

We looked at minutes from a staff meeting in April 2015 which detailed significant levels of risk at the service. The minutes reflected "(Name) said he's been receiving a lot of Incident forms recently which could potentially result in investigations; confidentiality issues, information being shared with third parties, medication errors, medication being taken out of bucket and given to others, medication sheets being doctored, deprivation of liberty, complaints about staff attitude towards residents. Potentially two investigations which need following up. On the nursing side, staff need to tighten up. There have been so many medication errors it's only a matter of time before CQC come".

We asked to see responsive action planning in regards to the information recorded in the April 2015 staff meeting minutes and the registered manager explained that this had not been achieved.

We were specifically concerned about the negative culture throughout the staff team and asked the manager if she believed this was being appropriately addressed by senior staff, we asked the manager to explain recorded minutes from April 2015 when staff were informed "(name) added that there are other issues that need pursuing and that it wasn't just the RMN's, but ASW's too. There were so many incident reports being submitted that (name) was fed up of being involved with them, (name) agreed that things were bad but a lot of them could have been stopped before they happened".

The manager explained that she was not present at the meeting but could see how a negative approach may have been perceived by staff, that may prevent an open and transparent culture. The manager also explained that investigations were on going regarding concerns about workplace bullying between a small group of peers.

We looked at the service general risk assessment and noted this had been completed in March 2013 and reviewed in February 2015. However it was evident that specified actions in the risk assessment for example 'fire drills will be carried out every six months' had not been achieved placing people living at the service at risk of harm and injury.

Records showed that the registered manager or a peer manager would undertake audits of the service monthly. We looked at these records and found that some areas of concern had been identified however the manager was unable to evidence systems put into place to rectify and address the areas requiring improvement.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We found that we had not been notified about things we needed to know. For example, one person living at the service had been arrested when in the community this is classed as a reportable incident.

We found that the provider had issued customer satisfaction surveys in 2014 and that these were conducted on an annual basis. Five people (50%) responded. One part of the survey asked for ratings on several statements. Service users were asked to give a response to; are you treated with respect; do you know how to complain; would your complaint be taken seriously and finally do you feel safe using the service. For all questions, the majority of service users `strongly disagreed` with the statements. There was one further statement; `are the premises used for Richmond Fellowship services are clean and suitable. Five people responded (100%) and 4 (80%) strongly agreed with the statement. All respondents (100%) agreed that Richmond Fellowship had helped improve the quality of their lives and they would recommend the service to a friend.

We asked the manager if she had responded to the survey results and she was unable to evidence any formal responses but explained she had spoken with people who had completed the surveys when they were handed in.

Inadequate

Is the service well-led?

The manager told us that feedback from professionals, including surveys had never been conducted. The manager told us, "This is something we need to look at and consider for the future".

This amounted to a breach of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These were reviewed and updated regularly and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguarding, fire awareness, privacy and dignity, safeguarding adults, infection control and health and safety.

Some staff had worked at the service for many years and told us that they enjoyed their role. However other staff raised concerns about when issues were raised. They told us "Since you (CQC) have come in we are being told about new procedures, things are being actioned at last" and "I found myself talking about things at meetings but nothing happened, nothing changed, it was not right".

Staff confirmed "We do have regular contact with management and the regional manager normally visits about once a month" and "the manager is approachable, but she has to split her time between here and the other houses".

We spoke with the registered manager about her role and level of involvement at the service. She informed us that she was new to the position of registered manager and had been in post for nearly eighteen months, however was finding it difficult to manage the home and oversee two other properties that she is responsible for.

We met with the assistant operations director who received feedback on our last day of inspection, he explained: "I have got to say I did not realise the level of support here was as problematic as it is".

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have effective arrangements in place to ensure that the care and treatment of service users was appropriate, outlined to meet their needs and reflected their preferences.** **Regulation 9 (1) (a) (b) (3) (a).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not have suitable arrangements in place to ensure that people are treated with dignity and respect.** **Regulation 10 (1).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005.** **Regulation 11 (1) (2) (3).**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users.** **Regulation 12 (1) (2) (a) (b) (c) (d) (g).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. Regulation 13 (1) (2) (3) (5).**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider did not have suitable arrangements in place to ensure that the premises were clean, suitable for the purpose which they are being used and properly maintained.** **Regulation 15 (1) (a) (c) (e) (2).**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people at the service.** Regulation 18 (1) (2) (a) (b).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.