Voyage 1 Limited

Deja Vu

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?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires Improvement

Overall summary

This inspection was carried out on 17 and 23 March 2015 and was unannounced.

Deja Vu provides accommodation and personal care for up to seven people who have learning disabilities. Support is carried out in an extended property, with widened corridors in the downstairs area to support people who may also have a physical disability. At the time of our inspection there were seven people using the service. There was a large garden with a decked area and a sensory garden at the bottom.

Deja Vu has a registered manager in post. 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. At the time of our inspection the registered manager had been in post for five weeks.

People's support plans included risk assessments, however these were incomplete, not always accurate and

Summary of findings

in some cases contradictory. This made it difficult for staff to respond appropriately to identified risk. We identified some areas of risk which had not been considered by the provider and were therefore not responded to.

People were protected from the risks of abuse, because staff had received safeguarding training, were able to recognise and describe signs of abuse and knew how to report suspected abuse. The provider encouraged staff to report any concerns.

Staffing levels were planned and matched to people's assessed needs. Although there were sufficient staffing levels on both days of the inspection, on the first day there were significant numbers of agency staff. The provider was working hard to reduce the number of agency staff. There were suitable processes in place in relation to the recruitment of staff.

Medicines were stored and administered safely by staff who had been trained to do so. Staff had received medicines and epilepsy training in order to administer emergency medicines in relation to seizures.

The registered manager considered that everyone had capacity to consent to everyday care and support in the home. However, we found several areas where people had received medical treatment and it was not clear that the Mental Capacity Act 2005 (MCA) had been followed. The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Where people lack capacity to make specific decisions the home should act in accordance with the principles of the MCA.

Staff had received essential training to deliver the care and support for people living in the home, however some care plans stated that some people communicated using Makaton. Makaton is a language programme using signs and symbols to help people to communicate. Staff had not received training in the use of Makaton, and we did not see staff using Makaton during the inspection. This meant staff may not have been able to communicate effectively with people.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and was aware of a recent Supreme Court Judgement which widened and clarified the definition of the deprivation of liberty. Relevant applications had been submitted for people.

People chose meals on a weekly basis by pointing at pictures of different kinds of food. Staff managed the food pictures to ensure that the overall weekly menu was healthy and balanced. The daily menu was clearly displayed in the kitchen for people to see.

We observed staff behaving respectfully towards people, responding to vocalisations and using opportunities through music and singing to interact with people.

Many of the bedrooms were not personalised in accordance with people's known interests and personal preferences. Some were cluttered by general items such as cardboard boxes, blue roll and hand towels and did not meet people's physical needs. Most rooms had a neglected and uncared for appearance.

Decision making profiles were included within support plans. However, these were not consistent with communication plans. This made it difficult to ascertain to what extent people had been involved in decision making around their care. Most care plans stated that the person had a learning disability and therefore was not able to be involved in their support plan. However, there was no evidence that this had been tested to ensure people were involved as much as they were able to.

We observed staff to be caring and supportive, engaging in activities with people such as reading books, playing instruments and games and colouring. People smiled showing they enjoyed the interaction.

People's support plans included a range of documents to support their care. However, not all parts of the plan were properly completed or up to date. Some plans were not clear or there were multiple plans which contradicted one another. The plans were not in a consistent format and did not accurately describe everyone's needs. There were no person centred plans in place. This made it hard to see how responsive personalised care was fully being offered.

People took part in activities at a local day centre, went for walks and engaged in cooking and other household

Summary of findings

chores as far as they were able. There was no evidence that activities were part of a person centred plan around the person's known hobbies and interests, or directed towards identified goals and aspirations.

The registered manager held regular staff meetings at which she actively encouraged feedback from staff. A detailed agenda was on the wall in the office in preparation for the next meeting and staff were able to add other agenda items they wished to discuss. Staff said they felt listened to by the manager, and felt confident that any concerns raised would be appropriately responded to.

The registered manager had only been in post for five weeks at the time of our inspection, therefore it was difficult to evidence a positive culture in such a short space of time. However, staff were positive about her appointment and were supportive of the changes and improvements she planned to make. They found the registered manager to be approachable, honest and open.

The vision and values for the provider were clearly displayed in the office and these included passion for care, positive energy and freedom to succeed. A clear vision and set of values had not yet been developed at a service level. Once these had been developed staff would be able to 'buy in' to the future of the home and contribute to its potential to succeed.

Appropriate Care Quality Commission (CQC) notifications had been submitted and there was an open and honest working relationship, which meant the registered manager openly discussed any issues with a view to ensuring swift and appropriate action.

The service required improvements across the board. The recent appointment of the registered manager meant that she had not yet had time to instigate real change; however she told us she had plans to do so.

During our inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 corresponding to four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Risk assessments were not always complete and accurate.

Staff knew how to keep people safe from harm and protect them from abuse.

Staffing levels were planned and matched to people's assessed needs.

Medicines were administered safely by staff who had been trained to do so.

Requires Improvement

Is the service effective?
The service was not always effective.

It was not clear that valid consent was always obtained for medical procedures because the provider had not followed the principles of the Mental Capacity Act 2005 (MCA).

People received care and support from staff who had been appropriately trained.

Requires Improvement

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

Many of the bedrooms were not personalised in accordance with people's known interests and personal preferences. Most rooms had a neglected and uncared for appearance.

People were not involved in their support planning. Care plans were not person centred.

Staff behaved respectfully towards people.

Requires Improvement

Is the service responsive?
The service was not responsive.

People's support plans did not always accurately describe people's needs. As a result there was insufficient guidance for staff to enable them to provide care responsive to the individual's needs. Plans had not always been completed or updated as required.

The registered manager encouraged feedback from relatives and staff.

Inadequate

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

The registered manager had been in post for five weeks at the time of our inspection. This was not sufficient time to demonstrate the qualities of well led and to instigate the changes the service required to improve.

Requires Improvement

Summary of findings

Organisational values of passion for care, positive energy and were displayed in the home but it was difficult to establish whether these had been embedded due to lack of consistent staffing and the recent appointment of the registered manager.

Quality assurance systems were in place but were not always effective.

Deja Vu

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 inspection was carried out on 17 and 23 March 2015 and was unannounced. The inspection was carried out by an inspector and a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge. In this case their skills and knowledge were with people who are living with a learning disability.

Before the inspection, we reviewed all the information we held about the home including the previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection.

During our inspection we observed and interacted with five people. We also spoke with the registered manager and two support staff. We reviewed records relating to the management of the home, such as audits, and reviewed two staff records. We also reviewed records relating to four people's care and support such as their support plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation.

We last inspected the home in April 2013 and found no concerns.

Requires Improvement

Is the service safe?

Our findings

One person had a 'Keeping Safe' plan in their records. This was because they had been put at risk by another person who uses the service. Some of the recommendations had not been actioned promptly and remained outstanding at the time of the inspection. There were other potential actions, which the home had not yet considered, which could have been put in place to support the person's safety.

Support plans included appropriate risk assessments. These included areas such as keeping safe in the garden, being involved in support planning, care of epilepsy and for one person, care and support around a recent operation following an injury. However, not all the forms were fully completed and some plans contradicted one another. This meant risk management was not always clear. For example tools such as 'what's important to me' and 'what's important for me' balance what is important to the person against what is important for the person, including consideration of any associated risk. An example of this would be 'I love drinking coca cola which is important to me' with a balancing risk of what is important for me 'I enjoy it in moderation as it is full of sugar and caffeine.' Records showed that risk had not been addressed in this way in the home because the second part 'what is important for me' had not been completed. This meant that some people may be at risk because it was not clear that all risks had been identified and addressed.

Other areas of risk which had not been considered involved one person who had sustained an injury during a seizure at night. A specialist in epilepsy was consulted following the inspection. They considered that the injury sustained during a seizure was highly unusual and highly preventable. There was no evidence that the home had looked at ways of preventing injury during a seizure such as having a double bed and using anti-suffocation pillows. Following seizures the person was extremely vulnerable as they were often assaulted by another person. A pressure mat had been requested to ensure the other person didn't enter their room at night, however best interest paperwork remained unsigned by relatives a month after the decision had been made, and the pressure mat was not being used. This person also had a step down into their bedroom. Following their recent surgery this may have made entry to their bedroom painful or risky as a walking aid was required.

All of the above meant there was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment.

Incidents and accidents were recorded appropriately and investigated where necessary, however there was no evidence of learning from incidents. This meant that the provider was not learning from risks identified as a result of incidents. The registered manager told us she planned to do a monthly evaluation of incidents in order to identify trends and learning. This linked to the development of risk assessments and risk action plans identified above.

There were arrangements in place for emergency situations. Regular evacuations were practised and personal evacuation plans were in place for each person. A fire safety audit was carried out monthly and actions identified. A problem with an emergency door, identified as part of this audit, had been reported on 2 March 2015, however the problem had not been rectified by the time of our inspection on 17 March. The emergency door was in a room which was not currently in use due to other issues. When we arrived in the home on 23 March, the fire panel showed there was a problem with the fire alarm system. We contacted the company responsible for the fire alarm maintenance. They told us they had carried out checks and confirmed that the fire alarm was fully operational in all rooms apart from the quiet room where a water leak had caused the ceiling to collapse. Additionally we contacted a Health and Safety inspector who visited the home on the same day. They concluded that all appropriate actions had been taken to mitigate the risk of a fire in the quiet room and a smoke alarm immediately outside the door would be an early warning of any fire. This meant, that the home had taken action to keep people safe, whilst the problem with the ceiling was assessed and fixed.

Staff had received safeguarding training and were able to describe sources and signs of abuse and potential harm. They also knew how to report abuse. One member of staff said "If you notice abuse you should report it immediately to the manager or the police. We are here to protect them." The relevant telephone numbers and procedures were displayed in the registered manager's office. The registered manager ensured that staff knew about the safeguarding and whistleblowing policies. Safeguarding was discussed regularly during staff meetings as a standard agenda item.

Requires Improvement

Is the service safe?

Cards were handed out to staff entitled 'See something, say something.' The cards gave clear instructions to staff about how to report any concerns about the service. Staff said they would feel able to whistle-blow, if necessary, without fear of reprisal.

The registered manager explained how staffing was allocated based on people's known and assessed needs. This meant that six members of staff were on a day shift and three were on a night shift. In addition the registered manager was available to cover any emergencies. The rosters reflected the staffing and skill mix described. Emergencies such as sickness were mostly covered by staff picking up extra shifts. On 17 March 2015 four of the six staff on a day shift were agency staff. Historical staffing problems and the constant use of agency staff had contributed to some inconsistencies in people's care and staff knowledge of people's individual needs. During the previous few months the provider had worked hard to recruit staff. They employed a mixture of new and experienced staff and had also transferred staff from other homes run by the same provider. The registered manager planned that staff knowledge and the consistency of people's care would improve as a result of this.

There were robust recruitment procedures in place, which were followed by the registered manager. Disclosure and Barring (DBS) checks were carried out before anyone could be recruited. These checks identify if prospective staff had a criminal record or were barred from working with people at risk. Potential staff had to provide two satisfactory references and a full employment history. This meant the provider was taking action to ensure that suitable staff were employed.

Medicines were administered safely by staff who had been trained to do so. Staff had received medicine and epilepsy training in order to administer emergency medicines in relation to seizures. We reviewed records in relation to medicines. Medication Administration Records (MAR) were kept for each person. These were all signed appropriately with no gaps. Medication stock levels were monitored and recorded each time medicines were administered.

Medicines were stored safely in a locked cabinet, in a locked room. A medication profile was kept for each person which included a photo, diagnosis, allergies, list of medicines and an administration protocol for 'as required' medicines. Current medicines were listed for each person in conjunction with relevant medicine information leaflets. A selection of medicines from the cabinet were checked and all were within date. We found the procedures displayed for action to take in the event of a medication error were out of date and included names of people who no longer worked for the service. The registered manager removed the procedures immediately and said she would get them updated.

Requires Improvement

Is the service effective?

Our findings

Observation in the home demonstrated that staff communicated effectively with some people. One person was assisting to prepare lunch. The member of staff supporting them gave regular verbal prompts which the person understood and complied with. They stayed on task and clearly demonstrated they enjoyed the activity.

The registered manager considered that everyone had capacity to consent to everyday care and support in the home, however, we found several areas where people had received medical treatment and it was not clear that the Mental Capacity Act 2005 (MCA) had been followed. The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Where people lacked capacity to make specific decisions the staff should act in accordance with the principles of the MCA. For example one person required blood tests. The care plan described a situation whereby, if the person stayed in the vicinity when the injection was offered, this was as assumed to indicate consent. However the "NHS Conditions to Consent" state 'Patients may passively allow treatment to take place – for example, by holding out an arm to show they are happy to have a blood test. However, since the capacity to consent has not been tested, and the benefits and risks have not been explained, this is not the same as consent.' The person's care plan stated 'Blood tests will be more successful if (the person) doesn't see the needle first.' There was no evidence of how the blood test was explained to the person, how they knew what was going to happen and how they may choose to give consent. It was not clear whether the person was verbally asked for their consent or if the person knew what a blood test was and had the capacity to understand this. Evidence suggested that the person may not have been giving valid consent for blood tests.

Similarly another person required an influenza immunisation. There was no mental capacity or best interest decision recorded around this to ensure valid consent. The person's support plan said '(the person) will hold their arm out.' This suggested that the person had not given valid consent. It had been determined that another person was to have a sensor in their room because they often went into other people's rooms at night. There was no assessment of the person's capacity to consent to the sensor being put in place although the registered manager told us they were waiting for relatives to sign a best interest decision. A best interest decision may have been made without assessing the person's capacity which is a pre-requisite.

The above represented a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the need for consent.

Support plans included a decision making profile which included information such as how the person liked to be given information, the best way to present choices and ways that staff could help them to understand. However, the profiles did not link in with information included in the communication plan, meaning there was not a coherent plan in place about how people communicated choices and how the person liked to communicate their decision.

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed that training covered all essential areas such as medication, food hygiene and fire safety. There was also training about understanding behaviour and values and attitudes. Some people's care plans stated they were able to communicate using Makaton. Makaton is a language programme using signs and symbols to help people to communicate. We did not observe any staff using Makaton signs to communicate with people.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made and was aware of the Supreme Court Judgement which widened and clarified the definition of the deprivation of liberty. Relevant applications had been submitted for people.

People chose their meals on a weekly basis by pointing at pictures of different kinds of food. Staff managed the food pictures to ensure that the overall weekly menu was healthy and balanced. The menus were displayed in the kitchen so people could see what they were going to eat that day. One person had a speech and language therapist (SALT) assessment in 2011 in relation to their dietary

Requires Improvement

Is the service effective?

requirements, and staff were following the guidance. However, there was no evidence of an updated review. This meant there was a risk that staff were following guidance which was no longer relevant, as the guidance had not been reviewed and the person's needs may have changed. There was fruit available in the home and people were able to have drinks and snacks when they wanted them.

Health professionals were involved in people's care. People were taken to see the GP when needed and various tests had been carried out.

Requires Improvement

Is the service caring?

Our findings

We observed staff behaving respectfully towards people, responding to vocalisations and using opportunities through music and singing to interact with people. Another person was observed to make their own drink of hot chocolate with support from staff.

We noticed that many of the bedrooms were not personalised. One person's support plan said they liked sensory interaction, however it was clear from the person's bedroom that their sensory requirement was not being met and there was no sensory equipment. Blue roll and paper towels reinforced the de-personalised nature of the room. A CD player was present but not plugged in and boxes from a new bath chair remained in the room, so it looked cluttered. There was a photograph album in the room but nothing was dated or labelled so it would have been difficult for staff to share the album with them and encourage communication because they did not know who everyone was. There was a small chair in the room which looked very low for the person to sit on, as their movement was restricted while they recovered from recent surgery. The quiet room, used to support people's recovery from pain, was out of use, because the ceiling had collapsed. No alternative room had been provided to support people's recovery.

One person's support plan stated they liked soft toys with big eyes, however these toys were only seen on the flat roof where the person had thrown them. It was not clear why the toys had not been retrieved for the person's enjoyment and whether plans had been put in place to prevent the person losing toys which were important to them. Although staff told us the person liked soft toys with large eyes and 'Spiderman,' there was no evidence in their room of either of these interests. The bedding displayed a childish character and was very old and well washed and did not tie in with any known interests. The person required a catheter and the night stand for the catheter was visible, which was not very dignified. There were shelves with nebulous ornaments which did not reflect anything about the person. The room looked neglected and not -personalised.

Another person had an activities timetable dated 2009 displayed behind perspex in their room. We noticed the curtains were thin and of poor quality which might have made it difficult for the person to sleep and rest well.

Some people had bedrooms which had been decorated to their tastes and known interests. For example one person had a colourful bedroom themed around purple. Pictures on the walls reflected their personality and their love of colour and butterflies. Another person's room was decorated in pink. It was clear the person liked pink because they were also dressed in pink. We noticed the en-suite bathroom smelt of urine and did not contain any toilet roll. Staff told us the person accessed the toilet independently but had a tendency to block the toilet and therefore toilet paper had been removed. This was not very dignified for the person and raised a concern about how the person maintained personal hygiene.

Decision making profiles were included in support plans however these were not in line with communication plans. This made it difficult to ascertain to what extent the person had been involved in decision making around their care. Staff were not seen to use Makaton which was a specific way of communicating for some people and would have enabled them to be more involved in their support planning. Most care plans said that the person had a learning disability and therefore was not able to be involved in their support plan but there was no evidence that this had been tested to ensure people were involved as much as they were able.

Support plans included positive images of people and there were good examples of families being kept up to date and involved in their relative's care and support. One person really like umbrellas and staff indulged them with many conversations about their umbrella. We observed staff to be caring and supportive, engaging in activities with people such as reading books, playing instruments and games and colouring. People enjoyed the interaction.

Staff knocked on people's bedroom doors before entering during our inspection. However, the registered manager walked in on a person having private time in their room during the inspection because they had not waited for a response before entering. There was no support plan in place to ensure people had private time in their room whenever they wanted it.

Inadequate

Is the service responsive?

Our findings

One person preferred to spend a substantial part of their time sat at the top of the stairs outside their bedroom door. Staff responded appropriately to this by checking on them regularly and on each occasion encouraging them to come downstairs. The person seemed happy with this.

Support plans included a range of documents to support people's care. These included personal details, a relationship map, a one page profile, 'important to and for me', a typical day, communication plan, decision making profile, social history and assessments. However, not all parts of the plan had been completed or updated as required. Some plans were not clear or there were multiple plans which contradicted one another. The plans were not in a consistent format and did not accurately describe each person's needs. There were no person centred plans in place. This made it hard to see how responsive personalised care was fully being offered. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating good governance.

One person's plan said they used Makaton but we did not see any evidence of staff communicating with them in this way. There was no support plan around the person's sexuality although they were known to enjoy private time in their room. Records within the support plan showed it had been reviewed in 2009, 2010 and 2011. There was no evidence that the plan had been reviewed more recently than this. Their dysphasia review report was dated 2006. **Dysphasia** is a partial or complete impairment of the ability to communicate. Their care plan said they needed help with menstruation but the menstruation record within their support plan was blank. It was not clear whether support had been given and if so how it had been given.

Another person had an elimination care plan in place which did not correspond with another care plan which said they had a catheter. The home had not responded to another person's sensory need by providing sensory equipment. Staff did not respond appropriately to pain demonstrated by one person. Whilst recovering from surgery, the person tried to sit on a low sofa. As they lowered themselves we saw them wince and make a noise that indicated they may be in pain, and they were holding their knee. Staff seemed unaware of these indicators of pain. We identified to staff that the person was in pain and the sofa may be too low for them. The person was on a programme of pain relief withdrawal following surgery, however staff had not discussed the person's continuing pain with the GP, to ensure they were able to access adequate pain relief. We asked the registered manager to arrange for the person to be reviewed by the GP as soon as possible. This meant the person may have been in pain and this may have been exacerbated by the height of the furniture which had not been reviewed following the person's injury.

People took part in activities at a local day centre, went for walks and engaged in cooking and other household chores as far as they were able. There was no evidence that activities were part of a person centred plan around the person's known hobbies and interests and directed towards identified goals and aspirations.

One person was noted to be very sleepy, and consistently fell asleep. Staff told us the person was not as lively as usual because they had had a seizure during the night. The seizure was not recorded in the record of the person's daily activities and also wasn't included in the person's night time recording. This information was found in another part of the file, but was not easily accessible. This was important information for people involved in the person's care and should have been clearly visible in their records. This meant that some staff may not have been aware that the person had had a recent seizure and would not have been able to respond accordingly.

All of the above demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person-centred care.

The registered manager held regular staff meetings at which she actively encouraged feedback from staff. A detailed agenda was on the wall in the office in preparation for the next meeting and staff were able to add other agenda items they wished to discuss. Staff said they felt listened to and responded to by the manager and felt confident in raising any concerns.

The registered manager had sent a letter to relatives shortly after her appointment. The letter encouraged feedback from relatives, invited them to come to her with any

Inadequate

Is the service responsive?

concerns and asked if there were any areas that they would like to see improved. At the time of our inspection, the registered manager had only received one response to the letter. She planned to take action as a result.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had only been in post for five weeks at the time of our inspection, therefore it was difficult to evidence a positive culture in such a short period of time. However, staff were positive about her appointment and were supportive of the changes and improvements she planned to make.

Staff told us that the registered manager was approachable, open and transparent. She was honest about things in the home which required improvement and made immediate changes in areas where we identified a risk. She was visible within the home and available to staff and people whenever needed. She had not yet had an opportunity to prepare a service improvement plan, because there were still actions to complete as part of a previous plan to address some safeguarding issues. The registered manager told us that links with the local community still needed to be developed.

The vision and values for the provider were clearly displayed in the office and these included passion for care, positive energy and freedom to succeed. A clear vision and set of values had not yet been developed at a service level. Once these had been developed staff would be able to 'buy in' to the future of the home and contribute to its potential to succeed.

Appropriate Care Quality Commission (CQC) notifications had been submitted and there was an open and honest working relationship, which meant the registered manager openly discussed any issues with a view to ensuring swift and appropriate action.

The service required improvements across the board. The recent appointment of the registered manager meant that she had not yet had time to instigate the required changes. However, she told us she had plans to do so.

Incidents and accidents were recorded appropriately; however there was no evidence of learning from incidents. The registered manager told us she planned to do a monthly evaluation of incidents in order to identify trends and learning in order to take action to minimise re-occurence.

There was some evidence of quality assurance in place, such as maintenance checks, but these were not always working effectively to monitor the quality of the provision of care and support for people. Some maintenance checks resulted in a report to the provider and a request for maintenance. These had not been followed up and remained outstanding for three weeks, which was unsafe for people. The operations manager carried out quarterly audits of the home however the latest audit reported that the home has 'passed' all aspects of the audit. In particular it referred to bedrooms being personalised. We found that not all bedrooms were personalised during our inspection. This meant the audits may not have been as robust as they should be, in order to ensure the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were met.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The care and treatment of service users was not appropriate to meet their needs and reflect their preferences. The registered person did not carry out an assessment of the needs and preferences for care and treatment of the service user, designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered person did not provide care and treatment of service users only with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person did not act in accordance with the 2005 Act. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users. The registered person did not assess the risks to the health and safety of service users of receiving care and treatment and do all that is reasonably practicable to mitigate any such risks. Regulation 12 (a) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to ensure compliance with the requirements in this Part. Such systems and processes must enable the registered person, in particular to, maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (c)