Voyage 1 Limited

Falcons Rest and Poachers Cottage

Inspection report

Falcons Rest
Bryngwyn
Wormelow
Herefordshire
HR2 8EQ

Tel: 01981542130
Website: www.voyagecare.com

Date of inspection visit:
10 July 2017
12 July 2017

Date of publication:
24 August 2017

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 10 and 12 July 2017. The first day of the inspection was unannounced.

Falcons Rest and Poachers Cottage provides accommodation and personal care for up to 14 people with a learning disability who may also have physical disabilities and/or sensory impairments in two purpose-built houses. At the time of our inspection, there were 11 people living at the home.

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was unavailable during our inspection. The provider's national service improvement manager, operations manager and temporary service manager were present.

The provider had not kept the training and competency of staff that administered medicines to people under review. There had also been a high rate of staff turnover at the service, which had resulted in fewer trained staff available to support people with social and therapeutic activities.

Staff understood the implications of the Mental Capacity Act 2005 for their work with people. However, people's right to make their own decisions about their own care and treatment was not always fully supported by the staff and management team.

People's care plans included details about what was important to them, and how to best support them. However, these plans had not always been reviewed to ensure the information and guidance provided was accurate and up to date.

A lack of consistent leadership and management meant staff were not always fully supported to fulfil their duties and responsibilities. The provider's quality assurance activities were not as effective as they needed to be.

Staff had received training in, and understood, how to recognise and report abuse. The risks to individuals had been assessed and plans put in place to manage these. The management team assessed and monitored people's staffing requirements, and followed safe recruitment practices.

People received individualised support to eat and drink, and any associated risks had been assessed with support from dietary and nutritional specialists. Staff supported people to access healthcare services and took prompt action when people were unwell.

Staff treated people with kindness and compassion and promoted their rights to privacy and dignity.

People's relatives knew how to raise complaints or concerns about the service. The provider had developed formal complaints procedures to ensure these were investigated and responded to appropriately.

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

The training and competence of staff involved in giving people their medicines had not always been kept under review. Staff knew how to recognise and report any abuse concerns. The risks to people had been assessed and plans implemented to manage these. Safe recruitment procedures were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

High staff turnover had affected the number of trained staff available to meet people's needs. Staff recognised people's rights under the Mental Capacity Act 2005. People were supported to have enough to eat and drink and any associated risks were assessed and managed. People had support to access healthcare services to ensure their health needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People had not been fully encouraged and enabled to participate in care planning and decision-making that affected them. Staff took a kind and compassionate approach to their work, and treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not received consistent support to participate in social and therapeutic activities. People's care plans contained details of what was important to them along with staff guidance on how to meet their individual care and support needs. People's relatives knew how to complain about the service, and the provider had formal procedures for handling such complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff did not always have the direction and support needed to succeed in their job roles. The provider's quality assurance activities had not enabled them to identify and address significant shortfalls in the quality of the service people received.	

Falcons Rest and Poachers Cottage

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 10 and 12 July 2017. The first day of our inspection was unannounced. The inspection team consisted of one inspector.

As part of our inspection, we reviewed the information we held about the service and information we received from other parties. We contacted representatives from the local authority and Healthwatch for their views about the service and looked at the local authority's quality and review monitoring visit report. We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

During our inspection, many people were unable to share their views on the service in detail due to their learning disabilities and communication needs. We spoke with one person who lived at the home, four relatives, a physiotherapist, a social worker, a dietician, a continuing healthcare case manager and lead, a community learning disability nurse and a team manager for adult disability services. We also spoke with the provider's national service improvement manager, operations manager, temporary service manager, six senior care staff and eight care staff.

We looked at three people's care records, medicines records, three staff recruitment records, the staff duty rota, complaints records, the home's menu, staff training records and records associated with the provider's quality assurance systems. We also spent time in the communal areas of the home to observe how staff supported and responded to people.

Requires Improvement

Is the service safe?

Our findings

Since April 2017, the provider had sent us a number of statutory notifications about medication administration errors at the service. During our inspection, staff indicated these errors were due, in part, to a lack of training and support to familiarise themselves with people's medicines and the home's administration procedures. They also referred to staffing problems and significant distractions whilst they were attempting to administer people's medicines safely and correctly. One staff member explained, "There have been times when I've had to take the service users around with me whilst administering others' medicines." Another staff member said, "Very often it's staff doing medicines who don't feel confident to do them, and they're trying to do two or three things at once."

We discussed these issues, and the frequency of medicine administration errors, with the provider's national service improvement manager. They acknowledged the concerns raised by staff, and accepted that medicine training and competency checks had not previously been completed to the expected standard. They indicated that previous medicine administration errors may not have been appropriately reported and recorded in line with the provider's procedures. The national service improvement manager had introduced a more robust system of medicine competency checks and training, which had led to the retraining of a number of staff. However, we were unable to test out the long-term effectiveness of this improved training and support at this inspection. They informed us that every effort was made to reduce distractions during medicine administration through maintaining appropriate staffing levels and providing clear behaviour support guidelines.

We saw the provider had put systems and procedures in place which should have ensured people received their medicines safely and as prescribed. These included the secure storage of people's medicines, up-to-date medicine records and issuing of additional staff guidance on the use of "when required" medicines and medicines applied to the skin.

We were not assured the training and competence of the staff responsible for the management and administration of medication had been consistently kept under review. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives felt confident their family members received safe care and support at the home. One relative told us, "Overall, we've been very pleased with [person's name's] care and we are satisfied they are not at risk there."

Staff received annual training in how to protect people from abuse. The staff we spoke with understood the different forms and potential signs of abuse, and the need to notify the management team of any such concerns without delay. The provider had procedures in place designed to ensure all abuse concerns were reported to the appropriate external agencies, such as the local authority, police and CQC, and thoroughly investigated. We saw evidence that previous abuse concerns had been formally investigated in line with these procedures.

The risks associated with people's individual care and support needs had been assessed, recorded and plans agreed to manage these. These assessments covered important aspects of people's personal safety, such as their physical health, behaviours, mobility and eating and drinking. However, we saw people's risk assessments had not always been reviewed and updated on a regular basis in line with the provider's procedures. We discussed this with the national service improvement manager. They acknowledged that the formal six-monthly reviews and monthly key worker reviews of these documents had lapsed. A key worker is a staff member given additional responsibilities to ensure an individual's needs and requirements are met, through working closely with the individual and their relatives. At the time of our inspection, the provider's internal quality team were undertaking a full review of people's care files. The national service improvement manager informed us the need for a consistent review process had been identified and would be addressed moving forward.

The provider had procedures in place to share information about changes in risk with the staff team. These included daily, recorded handovers between shifts and use of a "read and sign" folder when key documents were updated. Handover is a face-to-face meeting in which staff leaving work pass on important information to those arriving on duty. In the event that people were involved in an accident or incident, staff understood the need to report and record these adverse events. These reports were monitored and analysed by the management team, behaviour therapist and the provider's internal quality team to identify any action needed to minimise the risk of reoccurrence. People had access to a wide range of equipment associated with their personal care and mobility needs, including hoists, standing frames, shower beds and wheelchairs. The provider had procedures in place to ensure this equipment was checked and serviced at appropriate intervals.

Some people's relatives and some staff expressed concerns regarding the high staff turnover at the service, regular use of agency staffing and their impact on people's care and support. One relative said, "The problem is the continued high turnover of staff." The management team was actively recruiting to fill a number of care staff vacancies and a senior care staff vacancy. In the meantime, use was made of regular agency staff from preferred recruitment agencies to maintain staffing levels and promote continuity of care. One member of staff told us, "They (agency staff) all seem to know everyone really well."

The operations manager explained staffing levels at the home were calculated and monitored based upon the total number of care hours provided. Six of the staff we spoke with expressed concerns about insufficient staffing levels at Falcons Rest during the night. They felt there were not enough wake night staff on duty to safely respond to people's competing needs and certain incidents or emergencies. On this subject, one staff member said, "It's not safe for staff or clients."

We discussed this issue with the management team. They assured us people's staffing requirements during the night at Falcons Rest were kept under ongoing review through the completion of "night monitoring charts" by staff, analysed by the provider's behaviour therapist. The national service improvement manager indicated there had been no recent incidents highlighting significant concerns with the current night-time staffing arrangements. The provider had increased staffing levels between 9 p.m. and 12 a.m., and 6 a.m. and 7 a.m. in response to previous incidents.

The provider carried out pre-employment checks on all prospective staff to ensure they were suitable to work with people. These included employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS carries out criminal record checks to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Most of the community professionals and people's relatives we spoke with expressed concerns about the current skills and knowledge of staff. They pointed towards the impact of high staff turnover and regular use of agency staffing upon the proportion of trained staff on duty who also had good insight into people's individual needs. They also felt staff received a lack of training and support from the home's management team.

One relative told us, "I don't think they (staff) get enough training or support from head office." This person went on to describe the inconsistent support their family member received to participate in meaningful activities and increase their independence. Another relative referred to the lack of competent staff to ensure their family member received a nutritious diet. A physiotherapist highlighted the lack of experienced and confident staff to consistently support people with their physiotherapy exercises. One relative commented on the intermittent support their family member received with this aspect of their care. A dietician expressed concerns about the limited number of staff trained in how to respond if a person's feeding tube (PEG tube) came out. A social care professional told us, "We have lots of evidence staff are not properly trained." They referred to recent medication errors at the service as evidence of inadequate training. The staff we spoke with did not raise any significant concerns about training provision, aside from concerns regarding a lack of familiarity with people's medicines and the home's administration procedures.

We discussed the issue of staff training with the management team. They acknowledged the impact of recent staff turnover upon the number of fully trained staff. The national service improvement manager accepted that limited numbers of trained staff had affected the consistency of the support people received with physiotherapy exercises and communication techniques recommended by speech and language therapists. The management team assured us they had assessed and were addressing staff training needs as a matter of priority to ensure all staff had the appropriate skills and knowledge to work effectively. We saw they maintained up-to-date training records to help them keep on top of staff training.

Upon starting work at the home, staff were required to complete the provider's induction training to help them settle into their new job roles. This included the opportunity to work alongside and learn from more experienced staff, participate in initial training and read people's care plans. New agency staff were also provided with an induction to the home. The management team confirmed the provider's induction incorporated the requirements of the Care Certificate. The Care Certificate is a set of minimum standards that should be covered in the induction of all new care staff.

Most of the staff we spoke with were satisfied with the extent to which their induction training had prepared them for their work with people at the home. One staff member told us, "It was organised and has made sure I know what I'm doing before I'm put into any situation." Staff also met with a member of the management team at regular intervals, on a one-to-one basis, to receive feedback on their performance and discuss any additional support needs.

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.

We checked whether the service was working within the principles of the MCA. We found the management team and staff had a good understanding of people's rights under the MCA. Staff had received training to help them understand the implications of the MCA for their day-to-day work with people. One staff member told us, "It's determining whether people have capacity to make decisions about their care or simple decisions." Another staff member said, "We have to work with people's family to find out what's in their best interests if they lack capacity."

We saw evidence of mental capacity assessments and best-interests decision-making in the care files we looked at in relation, for example, to people's medicines and support with personal care. However, these assessments and decision-making processes had not always been completed in a decision-specific way or kept under regular review, as required under the MCA. The national service improvement manager acknowledged these issues, which, they informed us, had been identified during the current audit of people's care files by the provider's internal quality team. They assured us these issues would be addressed moving forward, in order to ensure people's rights under the MCA were being fully protected. During our time at the home, we saw staff consulted with people about their routine care, and respected people's choices and decisions regarding, for example, how they wanted to spend their time.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management team had submitted DoLS applications for people living at the home, based upon an individual assessment of their capacity and care arrangements. Where DoLS authorisations had been granted, the management team reviewed any associated conditions to ensure these were being complied with.

One person indicated they liked the food and drink provided at the home, and that they had enough to eat and drink. Most of the relatives we spoke with were satisfied with the support their family members received from staff to eat and drink and to maintain a nutritious diet. We saw people received unrushed, one-to-one support to eat and drink at mealtimes, with appropriate use of eating and drinking aids. People's dietary and nutritional needs were assessed and recorded in their care files. Plans were implemented to meet these needs with appropriate specialist advice from the speech and language therapists and dieticians.

We looked at how people were involved in decisions about food and drink. The home's menus listed two meal options for lunch and dinner. However, some of the staff we spoke with indicated a single meal was typically prepared, and that people were not actively given choices about what they ate and drank. On this subject, a relative told us, "[Person's name] has no choice." We discussed this issue with the national service improvement manager. They told us people were not being fully supported to make choices about what they ate and drank each day. They added that people's food-related likes and dislikes were not always appropriately assessed and recorded. The national service improvement manager informed us of the planned introduction of a pictorial menu system, and more robust procedures for involving people in decisions about food and drink.

People's relatives were satisfied with the support their family members received to maintain their health and access healthcare services. They told us staff responded promptly and appropriately to changes or deterioration in people's health, seeking professional medical advice and treatment as needed. We saw staff

provided people with support to attend routine medical appointments and health monitoring. People's current health needs were recorded in their care files, which included guidelines for staff on the management of people's long-term health conditions, including epilepsy.

Requires Improvement

Is the service caring?

Our findings

We looked at the support people had to express their views and be involved in decisions that affected them. People's care files included information about their communication needs and preferences, and the aids and strategies used to maintain and develop their communication skills. However, staff indicated these aids and strategies were not used on a consistent basis. A healthcare professional also expressed concerns about the lack of use of people's communication boards. We discussed this issue with the national service improvement manager. They acknowledged that people's communication aids and materials were not being used on a regular basis. This was due to a lack of staff trained in their expected use, who were also fully familiar with people's individual communication needs. They informed us referrals had been made to the speech and language therapy team, in order to reassess people's communication needs. Once these reassessments had been completed, staff would then be provided with the support and training needed to meet these needs, and make effective use of any communication aids.

In order to encourage people's involvement in care planning, key workers were, according to the provider's procedures, to meet with individuals on a monthly basis to discuss their current care and support. In addition, monthly "house meetings" were to be held to engage and consult with people more generally about the service they received, and invite their feedback and suggestions. However, we saw that both the monthly key worker meetings and house meetings had not been arranged on a consistent basis for a number of months. No additional means of involving people in care planning and decision-making had been introduced in the absence of these meetings. A healthcare professional expressed concerns about the lack of consultation with people at Falcons Rest on the recent key changes affecting that house. These related to the admission of two people from an associated home and the erection of security fencing around the home, blocking people's view of the grounds. We discussed this with the national service improvement manager who informed us they could find no record of any such consultation with people themselves.

At the time of our inspection, two people were accessing independent advocacy services to ensure their views and wishes were heard. The management team confirmed that people were signposted to and supported to access such services as necessary.

One person indicated they liked the staff and that staff treated them well. People's relatives felt staff adopted a kind and compassionate approach towards their work. One relative told us, "We've never noticed anything that would suggest they (staff) are anything other than caring and considerate people." This person went on to say, "They (staff) seem to adore [person's name]." Another relative said, "They (staff) seem very nice. They're very good with [person's name]." The staff we spoke with showed good insight into people's individual needs and preferences. During our time at the home, we saw people were relaxed in their home and at ease in the presence of staff. Staff greeted people and chatted with them in a warm and friendly manner. They listened to people and prioritised their needs and requests. Staff demonstrated their concern for people's comfort and wellbeing. For example, they confirmed people were seated comfortably during mealtimes, and offered prompt and effective reassurance to one person who was becoming anxious.

People's relatives felt staff respected their family members' privacy and dignity. The staff we spoke with

understood the need to promote people's privacy and dignity, and gave us examples of how they did this on a day-to-day basis. These included offering people choices and respecting their decisions, knocking on bedroom doors before entering and protecting people's modesty during personal care. During our inspection, we saw staff took steps to maintain people's privacy and dignity during personal care, and to protect their personal information. A healthcare professional raised concerns regarding the lack of support one person was receiving to increase their independence. This included involving the person in food preparation or giving them access to the TV remote control. We discussed this issue with the national service improvement manager. They acknowledged that not enough was being done to fully promote the independence of a number of people living at the home. They assured us this would be a primary focus of the service moving forward, and incorporated into people's activity programmes.

One of the relatives we spoke with raised concerns regarding the impact of one person's challenging behaviour upon their, and other relatives, ability to visit their family member at the home. We discussed their concerns with the national service improvement manager. They assured the provider's behavioural therapist had been involved in producing clear guidelines for staff on how to manage this situation.

Requires Improvement

Is the service responsive?

Our findings

Most of the community professionals we spoke with voiced concerns about the inconsistent support people received to participate in social and therapeutic activities. They referred to gaps in people's participation in hydrotherapy sessions and their in-house and community-based physiotherapy, due to a lack of trained staff. They also described a general lack of meaningful engagement with people on a day-to-day basis. A continuing healthcare coordinator told us, "There has been a complete lack of meaningful activities. We have given multiple suggestions to [registered manager] and have offered support, but these have not been acted on."

Some of the relatives we spoke with also expressed concerns about their family members' support with social and therapeutic activities. One parent told us, "There's no recognition that [person's name] needs more than a book in front of them." They went on to say, "In house, there is no education going on, and out of house it depends on whether there are drivers available." Another relative said, "No, [person's name] doesn't get enough meaningful activities; it's a lack of staff." Some of the staff we spoke with pointed towards the impact of a lack of trained staff and drivers on people's activities. One staff member told us, "There's a good amount to do here, but it would be nice to have the opportunity to get them out more. Sometimes, we don't have the right mix of staff." Another staff member said, "There's quite a lot of activities in house, but there are not many drivers, and a lack of permanent staff back here affects outings." During our time at the home, we saw people at the home spending their time using iPads, listening to music, watching TV, singing with staff and participating in a "messy play" session. Others were out and about doing personal shopping, having lunch out or going for a local walk.

We discussed the concerns raised in relation to people's social and therapeutic activities with the national service improvement manager. They acknowledged the impact staff turnover, limited numbers of drivers and a lack of strong senior staff had upon people's activities. They assured us steps were being taken to address these issues. Amongst these, additional senior care staff had and were being employed and new individualised activities plans had been introduced.

People's relatives expressed mixed views about the extent to which their involvement in assessments, care planning and decision-making involving their family members was encouraged. One relative told us, "We've been fully involved. We attend the annual review meeting and, if there are other meetings they feel we should attend, we are always given plenty of notice to attend. We're fully updated and informed." Other relatives told us the degree to which their involvement was encouraged varied significantly, dependent upon who was managing the home at the time.

In people's care files, we saw evidence of yearly review meetings, attended by people's relatives and the community professionals involved in their care. People's care plans included information about what was important to the individual, and their preferred daily routines, along with staff guidance on how to meet their individual care and support needs. Care plans had not been reviewed and updated in line with the provider's procedures. The national service improvement manager assured us these reviews would be carried out on a consistent basis moving forward. Staff understood the importance of following people's

care plans, and most staff told us they had the time and opportunity to read these. One staff member said, "All the information is in there. I've found them quite useful." During our time at the home, we saw people being supported in accordance with their care plans as, for example, they received assistance to eat and drink or move around the home. Staff had time to support people in an unrushed and unpressured way, and adjusted the nature of the support provided to suit people's individual needs.

People's relatives were clear how to raise concerns about their family members' care and support, by talking to the management team or the provider's senior management team. One relative told us, "I would quite simply ask for the next level above Poachers Cottage." People's relatives had varying degrees of confidence that their concerns would be listened to and acted upon within a reasonable timescale. One relative told us, "We have been consistently confident that our concerns would be listened to." Another relative said, "I'd speak to the home manager or assistant manager. They would take it on board and then inform head office. It then becomes a slow process."

The provider had developed formal procedures to encourage good complaints management. We looked at the most recent complaint received about the home, and saw the senior management team had investigated and responded to this. The provider and management team took further steps to encourage people's relatives to provide feedback on the service. These included the distribution of annual feedback questionnaires. The management team had also completed phone surveys with people's relatives in recent months, leading to the identification of some areas for improvement, which they were working to address.

Requires Improvement

Is the service well-led?

Our findings

People's relatives expressed concerns about the overall management of the service. One relative expressed their disappointment in the registered manager's lack of insight, at times, into their family member's current needs, adding, "It's a marvellous facility let down by sloppy management." Another relative said, "It (management support) is inadequate. Staff don't seem to know what they're supposed to be doing. It's very difficult to know whether there is any management going on at all." People's relatives told us the extent to which an open and inclusive culture was promoted within the service was dependent upon the registered manager at the time. One relative explained, "It varies fantastically. Some (managers) are good, and some are awful. Communication is a fundamental problem in the home and we are not told anything we don't ask about."

The community professionals we spoke with also raised significant concerns about the management of the service and the support provided by the provider's senior management team. These included comments regarding a lack of strong leadership and management within the service, poor communication from the management team and a loss of confidence in their ability to act on concerns and sustain positive change. For example, a dietician expressed their frustration over the lack of communication from the management team regarding one person who had moved out of the home, which could have adversely affected the management of their feeding tube. A social care professional told us, "As soon as they (provider) take their foot off the gas and stop monitoring things, they slip back again," They went on to say, "The leadership and management of the service is fractured and flawed at the level of the home."

People's relatives and the community professionals we spoke with also commented on the adverse impact of the regular changes in managers of the service, in terms of enabling a consistent management approach.

A number of staff expressed anxiety and frustration over a lack of information, effective communication and clear direction from the management team. One staff member told us, "We have questions about how best to support people and get told they don't know. It's very frustrating." Another staff member said, "We seem to be disjointed; information doesn't get passed over." A further member of staff told us, "It feels like you're working alone. They (management) don't update you on the situation. You just hear rumours. There are no straight answers; there's no communication. You don't know what's going on. You just feel very stressed." These staff members told us the lack clear communication and direction from management left them feeling unsupported and resulted in a disorganised approach to people's care and support. One staff member explained, "I do think it's a bit of a shambles. Staff don't know where they are really. You come on shift and don't know who's shift leading. There's very much a lack of structure; it's very much chaotic." Another member of staff said, "If you're not looking after your staff they're going to leave." This person went on to say, "I don't feel supported and I don't want to be in a place where I don't feel safe." All of the staff we spoke with felt there was someone amongst the management team they could approach with any issues or concerns. However, some staff lacked confidence these issues would be acted upon, based upon their previous experiences.

We discussed the concerns raised regarding the management of the service with the management team.

They told us the operations manager and managing director had met with staff, and that further staff meetings had been held, to answer staff members' questions and allay any concerns over recent changes at the service. We saw evidence of staff meetings during our inspection. The provider had brought in the national service improvement manager and additional management support from associated homes to oversee the management of the service whilst the registered manager was away from work. Some staff commented positively on the impact of the temporary management arrangements. One staff member told us, "I have noticed a big difference with [national service improvement manager] coming in. They are there for advice and to sort things out." Additional senior care staff had also been employed to provide staff with additional guidance and support on shift. Handover procedures had also been improved, requiring the manager to be present during handover.

During our inspection, it came to our attention that the management team had failed to notify CQC of two recent allegations of abuse, in accordance with their registration with us. The management team demonstrated a good understanding of the requirements of their registration, and acknowledged this was an oversight on their part. We saw the allegations in question had been fully investigated by the provider.

The provider had put quality assurance systems and procedures in place. These included a rolling programme of audits by the registered manager, operations manager and the provider's internal quality team to feed into a consolidated action plan. Regular audits and checks on people's medicines, and weekly health and safety and infection control audits were also carried out. The provider's national service improvement manager was coordinating and overseeing quality improvement at the service.

The management team explained that these quality assurance activities had led to recent improvements in staff training, and the introduction of new activities programmes and more in-depth cleaning schedules.

However, we were not assured that the provider's quality assurance was as effective as it needed to be. It had not enabled the provider to highlight and address, in a timely manner, the significant shortfalls in quality we identified during our inspection. These included concerns regarding the training and competence of staff responsible for the administration of medication, and the lack of consistent involvement of people in care planning and other decision-making that affected them.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment The training and competence of staff involved the administration of medication had not been kept under review.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes had not enabled them to identify and address significant shortfalls in the quality of the service.