Parkcare Homes (No.2) Limited

Devon House

Inspection report

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Date of inspection visit:
12 September 2017
14 September 2017

Date of publication:
24 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 14 September 2017 and was unannounced.

The previous comprehensive inspection took place on 23 January 2017. At that inspection we found there were three breaches of regulations. These related to staff supervision, lack of person centred care in relation to activities and governance of the service. We served a Warning Notice on the provider in relation to governance of the service.

We carried out this comprehensive inspection to follow up on the Warning Notice and ensure the requirements of the regulations were now being met.

Supervisions were now taking place at the service and activities had improved to some extent. However, there remained a breach in relation to the governance of the service. In addition we found breaches of regulations in relation to risk assessments, safe management of medicines, safeguarding service users from abuse and improper treatment and the need for consent. We also found one incident which should have been notified to the Care Quality Commission and had not been notified. This was a breach of the regulations.

Devon House provides accommodation, nursing care and support with personal care for up to 11 people. At the time of our visit, nine people lived at the home who needed support due to acquired brain injuries or neuro-disabilities.

The home had a registered manager in place during our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 this inspection we found medicines were not being managed safely. There were errors when reconciling stocks against medicines for boxed medicines and one controlled drug was stored on the premises when it should have been returned to the pharmacist or destroyed.

Although a number of risk assessments were in place and up to date, there were insufficient risk assessments for a person who had recently used the service twice for respite. We also noted two other risk assessments which were either inaccurate or contained information which was contradictory.

Although there was appropriate documentation in place to restrict some people's liberty due to their vulnerability, two people were being monitored at night without the appropriate safeguards in place.

Accidents, incidents and behaviour logs were not always being reviewed by the registered manager with remedial action taken which meant people were not always safeguarded from abuse or harm. We were

concerned there was an under-reporting of instances of behaviours that challenge.

The provider did not address adequately concerns around safeguarding or consent.

Group staff supervision was now taking place regularly and staff told us they received regular supervision which they found helpful. New staff undertook an induction, and all staff completed training in key areas.

At the last inspection people and their relatives told us activities were not regular and records did not detail if people were taking part in regular activities. At this inspection we found each person had an activity plan in place and their activities were usually recorded on their daily record. However, at the time of the inspection the service had not recruited to the post of activity co-ordinator, although an advert had been placed. Some trips out had been organised in recent months, and people went for a coffee or the shops locally. At the time of the inspection people continued to spend a lot of time at the service carrying out activities on site.

At the last inspection we found one person's Percutaneous Endoscopic Gastrostomy (PEG) tube feeding schedule was not easily accessible to staff. Fluid balance charts for people with PEG tubes did not have 24-hour totals to reflect the overall intake which could impact on health and well being. At this inspection we found PEG charts were available to staff but were tallied at different times. We have made a recommendation in relation to this.

At the last inspection there were concerns as daily records were not being completed in full to accurately describe people's activities and the registered manager was unable to locate one person's daily notes covering nine days. At this inspection we found the majority of daily notes were being completed. However daily notes for one person in respite did not fully document their food or fluid intake.

Although there was a complaints process in place, there were no records of complaints since 2016 despite details of complaints being evident on other documents.

On the day of the inspection staffing levels were adequate to meet people's needs. However we were made aware by the registered manager and staff that care staff preparing food for people at the weekend impacted on their availability to provide care. Funding had been agreed but not implemented to recruit a chef at the weekend. Following the inspection chef support at weekends was put in place.

We witnessed kind interactions between staff and people on the day of the inspection. The majority of people told us they found staff kind and caring and this was confirmed by the majority of relatives.

Safe staff recruitment procedures were in place.

Safety checks of utilities and fire equipment had taken place in the last 12 months. We noted moving and handling equipment had been checked and was regularly serviced.

We found breaches in relation to the safe management of medicines, safeguarding service users from abuse, consent and governance. We also found a breach of the regulation relating to notifying CQC of important events. We are considering our regulatory response to this latter concern.

We have made a recommendation in relation to complaints and fluid charts.

You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were not always risk assessments in place to provide staff with guidance.

Medicines were not always managed safely.

Although staff could tell us about safeguarding people from abuse the improper management of incidents and behaviour logs meant people were at risk of abuse.

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There were safe recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective. There were Deprivation of Liberty Safeguards (DoLS) assessments undertaken for people who required them. However the provider had exceeded the authority given by the local authority for two people by visually and audibly monitoring them at night without permission.

Staff were receiving supervision on a regular basis in accordance with the provider's policy.

People were provided with a healthy menu to eat, but were not provided with sufficient choice. This changed following the inspection.

People had access to physical healthcare services. There was under-reporting of behaviours that challenge.

Is the service caring?

Good

The service was caring. People were encouraged to be independent.

We witnessed kind interactions between staff and people living at the service.

The garden had been improved and now provided an expansive pleasant space outside for people to use.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although activities took place, these were predominantly at the service with limited trips outside of the local café or shops.

There was a complaints process in place, but the registered manager did not always identify issues raised as a complaint.

Care plans included people's care and support needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Whilst the service was receiving additional management support from the provider to improve care, we found quality concerns in a number of areas.

There was an auditing process in place that had identified and led to improvements in some areas, but not other areas of concern highlighted by the inspection.

The registered manager was well regarded by staff and people using the service.

Devon House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was carried out on 12 and 14 September 2017 and was unannounced. The inspection team comprised of one inspector, a specialist nurse advisor 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.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people.

During the inspection we spoke with four people, the registered manager, a registered nurse and two staff. We observed interactions between people and staff members to ensure the relationship between staff and people was positive and caring.

We looked at documents and records that related to people's care and the management of the home. We looked at seven care plans, which included risk assessments.

We reviewed three staff files and looked at eight staff supervision records. We looked at other documents held at the home such as training records, medicine administration records and health and safety information.

As part of the feedback we spoke with the Clinical Performance Director. We also communicated extensively with the Clinical Performance Director and management of the service following the inspection to obtain additional information and feedback on actions taken by the provider.

We spoke with four relatives and officers from the local authority.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe living at the service. One person told us "Yes" and they thought the safety of the premises were "very good". Two people said they didn't feel safe. One person was unable to explain why they did not feel safe, another said they felt unsafe because of staff. We have made the provider aware of this concern and they have taken appropriate steps to manage this and alert the relevant authorities to this concern.

Staff could tell us the different types of abuse and were clear that incidents between people at the service should be considered a safeguarding issue.

However, we noted that whilst there were protocols in place to set out action to be taken in the case of incidents or behaviours that challenge, these were not always followed by the registered manager. For example, we noted that one incident of assault that occurred in May 2017 between two people was not considered a safeguarding incident.

We also found by looking through the service's behaviour log that three incidents with one person related to moving and handling were not followed up with remedial action or considered as safeguarding concerns. Documentation relating to one of these incidents noted "[person's name] became aggressive and screamed at the staff saying they hurt her. This was not true." The resolution was noted as the nurse in charge calming the person and assisting with hoisting the person out of bed. The two other incidents noted the person felt 'stuck' or was being 'swung about' in the hoist. This meant the person's moving and handling requirements were not reviewed at the time, in August 2017. This person had a pressure area at the time of these incidents. Following the inspection in September, remedial action has been taken and this person's moving and handling needs have been re-assessed.

We witnessed one person becoming extremely agitated. They were shouting very loudly and gesticulating aggressively standing over another person who lived at the service who was a wheelchair user. The registered manager moved the person in the wheelchair away. .However, when we discussed this incident with the registered manager they did not view it as a safeguarding issue, but following our discussion agreed to refer it to the local authority and CQC as a safeguarding incident.

These incidents were of concern as they illustrated the registered manager and members of the staff team had a lack of understanding of their responsibilities to safeguard people from abuse and improper treatment. This placed people at further risk of abuse and meant that other organisations were not notified of incidents as possible safeguarding concerns.

There were three incidents of falls that had occurred since the inspection in January 2017 which were not notified to the local authority.

We also found incidents of behaviours that challenge being recorded in daily notes, but not being logged using the ABC behaviour chart the provider had in place to log behaviours of concern. This suggested to us

an under reporting of incidents relating to behaviours that challenge taking place. This was of concern as it meant there was a lack of evidence to share with other health professionals, to seek appropriate support, and was not considered as having an impact on other people living at the service who witnessed these behaviours.

The above concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of detailed up to date risk assessments in place for people living at the service. However, a person who recently visited the service for respite care did not have detailed care records or risk assessments in place to provide information to staff for all of their needs. For example, despite this person using a wheelchair full time for mobility, there was no risk assessment in place regarding their requirements for safe transfer to and from the wheelchair. Neither was there information regarding this person's communication needs or how to support them with their epilepsy should they have a seizure. There was a one page document provided by the family which summarised this person's needs, but the service had not fully assessed the risks the person faced putting them at risk of unsafe care or treatment.

The registered manager told us the person who had come for respite had been known to some of the staff previously in 2014. However, the provider did not ensure there was a risk assessment in place despite this person having stayed in the service for two short periods of respite between August and September 2017.

One person who used a wheelchair to move around the home did not have a risk assessment that acknowledged they used the wheelchair. Their risk assessment stated they could use a walking frame, and needed to be reminded to use it and staff to ensure it remained in reach. The registered manager told us this person did not need to use a wheelchair for manoeuvring around the home but due to behavioural issues chose to. This was of concern as the service was using bank and agency staff on occasion to cover shifts and there was not an accurate record of the person's needs and risks placing them at risk of unsafe care.

We also noted another risk assessment contained contradictory information in the moving and handling section to information in the falls risk assessment which could have confused staff in how to support this person safely.

We checked whether medicines were safely stored and managed at the service. The medicine room was kept locked when not in use. Medicines were stored at a safe temperature and the temperature of the medicines fridge and room was recorded daily. The majority of medicines were packaged in blister packs. On checking stocks against records, accompanied by the registered manager, we found errors with two out of three boxed medicines. When checking stocks against records for three different boxed medicines, with the nurse on duty we found two errors.

The registered manager told us that a qualified nurse covering the night shift checked stocks against records every two weeks and recorded on the medicines administration record what they had checked. However, one PRN (as required) medicine stock had been carried over incorrectly and had not been checked within the two week period.

We could see the provider had had medicines audited in August 2017 by the pharmacist they used and had not found any errors. However, the provider could not show us there was a robust system at the service to routinely check stocks against records.

We noted in the controlled drugs cupboard an unopened bottle of Oxycontin liquid 250ml. This had

previously been prescribed for a person living at the service but was no longer prescribed. When we asked why this medicine had been kept the registered manager told us it had been kept to reassure a family member. This was not appropriate as the medicine could not have been given without a further prescription. The registered manager told us this would be destroyed. Following the inspection the provider told us this medicine had been destroyed.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three people at the service being administered medicines covertly. All three had letters of authorisation within their notes by either the GP or pharmacist and alongside the nursing staff, documentation relating to best interests decisions were on care records.

Two people had their drinks thickened to help mitigate the risk of choking. Whilst the chef was able to produce an information sheet from a folder in the kitchen advising how much thickening powder to use for each drink, we were not confident this was easily accessible for all staff. The registered manager told us they would put documentation in a more prominent position within a cupboard in the kitchen to ensure this information was available to all.

Two people were provided with nutrition via Percutaneous Endoscopic Gastrostomy feeds. The quantities were written on the MAR chart but we noted the fluid chart was not totalled correctly for the date of 11 September 2017 for one person. Both fluid balance charts had been partially, rather than fully, totalled before 10 pm on the previous night. No further entries were made between then and following morning. This could indicate issues with recording or potentially leave people at risk of dehydration.

We recommend that there is a system in place which stipulates how and when these charts are completed to ensure there is a consistency of approach by nursing staff.

The service was clean and we could see hygiene was checked as part of an auditing process. At the time of the inspection there was no provision for paid housekeeping staff at the weekend. Relatives noted staff were busier at the weekend and less available to provide care. Following the inspection it was confirmed by the provider there will be additional provision for housekeeping tasks until the service is redecorated throughout.

Staff recruitment was safe. Records showed appropriate references and Disclosure and Barring Service checks took place before staff were considered safe to start working. People and their relatives told us staffing levels appeared adequate to meet people's care needs during the week days. The registered manager told us if people had appointments they ensured additional staff were available to take them. However one person told us "At weekends there are not enough staff as sometimes, one has to do the cooking." Two relatives highlighted this as an issue. Staff told us they had to cook at the weekend and this impacted on their availability to support people. Whilst funding had been agreed prior to the inspection to increase chef support at the weekend, this had not been implemented. After the inspection the provider showed us that there was additional chef support at the weekend to ensure care staff could concentrate on their caring role.

Appropriate safety checks had taken place in relation to gas, electricity, moving and transferring and fire safety equipment at the premises. Window restrictors had been regularly checked to ensure they were in place on the first floor and were functioning correctly.

Requires Improvement

Is the service effective?

Our findings

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had applied for DoLS for those who required it and we could see from reports some people had been assessed under DoLS.

Care staff told us they understood the need for consent when offering care to people. One person said "Yes, [they] usually ask are you ready?" Two people told us they were not asked prior to being provided with care.

We also noted whilst the provider could show they had requested DoLS assessments for four people at the service, the provider had exceeded the authority given for two people by visually and audibly monitoring them at night without permission. We asked why there was this level of scrutiny of the individuals. The registered manager told us their family members were concerned they would fall out of bed. However, monitoring people in this way was not the least restrictive option to provide safe care. This illustrated a lack of understanding of the requirements of the MCA and acting in people's best interests.

This concern was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food was freshly prepared and two people told us they liked the food saying "Yes" and "Yes definitely so." One person told us they had to buy their own snacks. We asked the provider if people were offered snacks outside of mealtimes and were assured they were. People told us the chef chose the menu and one person's religious needs were met by having a halal option. Following the inspection the provider told us people living at the service chose the menu and there were different options available on a daily basis.

There was a speech and language therapy assessment for one individual on respite stay who required pureed food and specific support with eating. However, daily records for this person did not always have their food and drink intake recorded. This person could not communicate their needs and so was at risk of insufficient nutrition or fluid without staff understanding what they had eaten and drunk.

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

2014.

We noted a person on medicine for a suspected urinary tract infection was not having their fluid intake monitored. Following feedback from the nurse specialist on the first day of the inspection the registered manager started a fluid intake chart which was in place by the second day of the inspection.

Only one person responded to the question regarding the skills and knowledge of the staff. We were told "Yes very good care." Relatives had mixed views on the skills of the staff to care for their relatives. One family member told us they thought the care "was exemplary" whilst two relatives told us they thought staff should be more "proactive" in their role as they had to ask for their relatives room to be cleaned. Two relatives noted that agency staff were not as skilled in providing care for their family member as they did not fully understand their requirements. Following the inspection the manager covering the service at the time of writing this report told us they had been using agency staff with greater frequency due to staff absence and turnover. However, the provider was in the process of recruiting permanent staff and an experienced staff member was returning from leave. They also agreed to take up the issues raised by relatives regarding agency staff.

New staff undertook a two week induction which involved shadowing care staff, reading policies and completing online training.

At the last inspection we found a breach of the regulations as supervision was not taking place regularly. At this inspection, records showed supervision was taking place more regularly since January 2017 with a number of group supervisions taking place. The supervision log which indicated which supervisions had taken place did not fully tally with records of supervisions kept. We discussed this with the registered manager who said they would carry out spot checks to ensure all supervisions stated had taken place.

Staff confirmed supervisions took place more frequently in recent months and found them useful. Appraisals had taken place for the majority of staff in the last 12 months.

Staff training was up to date with training undertaken in key areas including moving and handling, medicines administration, and food hygiene. Practical behaviour support training had been undertaken by some staff at the time of the inspection and additional dates were planned for the remainder of the staff team.

We saw from records people had access to physical health services to meet their needs including the GP, dentist and secondary physical health services. We saw where one person had refused to attend for an investigation at the local hospital this was noted on their records. Another person had been referred to the brain injury medical team due to changes in their behaviour. Another person's neurological presentation was being reviewed but we were aware through discussion with the registered manager that not all incidences of behaviours that challenge were recorded and so a full picture of people's needs may not be evidenced. Following feedback at the inspection the Clinical Performance Director sent us policies which outlined the process to be undertaken in the event of behaviours that challenge and assured us these would be followed going forward.

Good

Is the service caring?

Our findings

We asked people if they found the staff kind, caring and patient. We were told "Yes, I would say so, yes". One person told us no, but would not expand further. Two out of three relatives told us they thought staff were kind, a third relative told us "Some of the staff are kind, [but] others have not got empathy for [relative] or others." We witnessed some kind and caring interactions between staff and people living at the service on the day of the inspection.

Staff were able to tell us how they would maintain people's dignity, by closing doors when providing personal care, by asking people what they wanted to wear and giving them choice in how care was provided.

We asked people if they were able to get up, go to bed when they wanted. Two people told us "Yeah" and "More or less, I would say yes".

We asked people if staff listened to their views about their care. One person told us ""Yeah, I think they do, yeah." We found some documents were signed by people living at the service if they had capacity and some people's relatives had been involved in their care planning. Not all documents had been signed by a person or their relative.

People told us their family and friends were always welcome at the service which they viewed positively. We also asked if people were supported with their spiritual needs. We were told, and this was confirmed by relatives, that some people were either supported to attend the local Catholic Church or religious leaders from this facility attended the service.

We noted one person who was deeply religious and who prayed several times a day had not been attending mosque recently although we could see on occasion they had been asked by staff if they wanted to attend. We asked the registered manager if the local mosque had been contacted and a religious leader invited to visit the person at the service. This had not been done. The registered manager said they would ask the person if they would like this and then make contact with the local mosque to see if this would be possible. The service respected this person's wish to be cared for by a male carer and halal meat was available to meet this person's religious requirements.

The garden had been recently improved and there was a large patio which was wheelchair accessible. People were in and out of the garden and it had been possible to have shared meals outside as a result of the improvements, which was positive for people.

Whilst some staff knew about people's backgrounds this was not always documented on their care records. This meant that knowledge was not easily available to all staff and given some people could not communicate verbally, it was important for staff to know and understand their background and who was important in their lives.

We saw that people were invited to attend residents' meetings to enable them to have their say in how the service was run, and records were available for us to view. People's rooms were personalised as they chose.

Requires Improvement

Is the service responsive?

Our findings

We found the majority of people had care records that were up to date and were person centred. They covered a range of areas including moving and handling, nutrition and personal care requirements. People's psychological or behavioural needs were not always documented accurately, and we found one person who used the service for respite did not have a support plan in place covering their communication needs, leisure or moving and handling requirements.
Whilst there were some elements of person centred care at the service, a family member told us they thought there were set days to have a shower for their relative. They told us in their experience if their relative was going out that day they were not offered a shower at a different time in the day when they returned. We noted one person in a resident's meeting had noted they would like more showers.

People had key workers who they met with regularly. We noted one person refused to meet with their key worker on a regular basis and this was documented, but there was no record of alternative attempts or solutions to engage this person.

At the last inspection there was a breach of the regulations as there were elements of care which were not person centred. We had noted that each person's daily notes did not detail if they had participated in the activities on the planner and we were concerned that people in wheelchairs did not have full access to the garden.

We also found that people did have planners in place and the activities they undertook were noted on the daily record. We noted that people's activities did not always tally with their planner which could be related to individual choice on the day but this was not recorded.

The service could evidence that some people had gone out on a day trip to the zoo, others for a drive to a local area, and others to a market near to where they used to live. People did go to the local shops and café with staff, but for some people there was a limited range of activities taking place, often based at the service.

People told us the number of activities had improved over the last six months, and residents' meeting minutes confirmed this was the case. This was also confirmed by relatives. One person said "I go shopping, go to charity shop, I go out to day centre. In the home we have pamper days, nails done and haircut."

We noted there were games and quizzes,and film afternoons, with popcorn and snacks. However, we saw one person whose care record noted they enjoyed photography but this had not been facilitated. The registered manager told us they were finding it difficult to engage with this person but there was no evidence of creative thinking with regard to engaging with them. Another person, who a staff member told us had been a painter and decorator, had said in the residents meeting they would like to do painting, but when we asked we were told they had been given crayon and felt tips to use. We saw one example where a person was supported to access their interests in music and theatre. There were four bookings in 12 months for musical artists to visit the service.

At this inspection we found the garden was now fully accessible which was positive for people as they were able to enjoy sitting out in good weather and the service had held some barbecues this summer.

We discussed the range of activities for all the people living at the service with the registered manager and the Clinical Performance Director, who could tell us how they had improved this provision, but acknowledged more could be done. At the time of the for the provider was recruiting an activities co-ordinator which the registered manager and Clinical Performance Director believed would help improve the offer for people living at the service.

We asked people if they knew how to make a complaint if they were not happy with the service. Two people told us they knew how to make a complaint. One of these people told us "I have done in the past and that has always been followed up."

We noted the provider had a complaints policy. We asked relatives if they knew how to make a complaint. They told us they would talk to the registered manager but were not aware of a formal complaints process. Two out of three relatives told us issues they raised were dealt with. A third relative told us they could speak with the registered manager if they were concerned. Although one relative told us if they raised things they sometimes felt the investigation lacked objectivity and they were not always confident the investigation was always transparent and open.

We looked at the service's complaints log. The last complaint logged was in February 2016. However we noted a specific staff meeting dealt with one person's issues raised as a complaint in March 2017 but not recorded as such. The minutes noted "[Person's name] feels she is neglected. Staff do not give her choice when getting dressed." The minutes also noted the person had stated staff were taking calls and using their phone when in this person's room. Actions were taken from this meeting and we could see that subsequent staff meetings reminded staff not to use their phone when providing care to people. We discussed this with the Clinical Performance Director who pointed out that the complaint had been dealt with, but acknowledged that it had not been logged as a complaint in line with the provider's policy.

We recommend the service reviews the implementation of the complaints process at the service to ensure the service is compliant with the provider process and relatives are fully aware of their right to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

As a result of the inspection in January 2017 a Warning Notice was served in relation to the governance of the service. Specific areas of concern in relation to governance were lack of detail relating to activities in people's daily records; staff supervision records had not been stored securely for November 2016; there were missing daily records for one person; and a person's fluid chart had not been totalled over a 24 hour period to prevent the risk of de-hydration.

At this inspection whilst we found the requirements relating to the Warning Notice had been largely met, there remained concerns relating to the governance of the service.

The provider had an established quality assurance process in place with written protocols and processes. As a result of the concerns related to the service following the inspection in January 2017 additional support was made available by the provider's Quality Assurance Team. Clinical Governance Meetings took place alongside clinical audits and internal compliance audits. We could see from records that audits by the Quality Assurance Team had taken place in May, July and August 2017. Following these audits an action plan was updated with actions achieved and those still outstanding.

At the end of August 2017 the provider carried out a comprehensive audit. This was useful as it highlighted a number of areas that had been improved by the time of the inspection. For example, food storage issues had been highlighted in August and rectified by the time of this inspection. Similarly an audit of the activities undertaken by people living at the service had identified that whilst there had been improvements, staff were in the main documenting activities of daily living as opposed to planned activities or groups and largely this was a record of what the staff had observed the service user doing. For example, watching television, or listening to music in their bedroom. As a result of the provider audit in August an advert had been placed for an activities co-ordinator, and staff were endeavouring to take people out of the service more regularly as well as running some activities at the service.

However, despite the intensive support to the service and the internal auditing process, a number of issues had not been picked up and remained of concern at this inspection. For example, although clinical audits had addressed a broad range of areas, they had not checked stocks against records for boxed medicines, and had not required the service to do so on a regular basis.

The provider auditing process had checked incidents recorded on the computer system and cross referenced these against safeguarding referrals made. The audit had noted some issues with records retained relating to safeguarding discussions with the local authority and had re-opened this as a concern on the provider action plan as a result of this. However, the audit had not scrutinised paper documented incidents or behavioural charts and so had not picked up the overlooked safeguarding concerns we found at the inspection related to May and August 2017.

Whilst there were a range of audits undertaken by the provider we found the provider and registered manager did not undertake sufficient scrutiny of the day to day management of the service and undertake

management tasks to spot check the quality of the care being provided. For example, it took some time to locate the supervision records for staff as these were not on staff files. When we asked the registered manager about this they could show us a supervision chart, but neither the provider nor the registered manager had spot checked records were in fact written and retained by supervisors. We found the majority of supervision records referred to on the chart once supervisors printed them off the computer, but not all. Similarly the provider and registered manager did not spot check medicines audits carried out by nursing staff every two weeks so had not detected the errors prior to our inspection. The provider's internal audit of end of August 2017 noted "The service lack strong underpinning management systems, though some are now in place, such as governance, they require considerable strengthening to be effective. "

We also found the registered manager lacked insight into the risks posed by not having up to date care documentation for a person being admitted for respite. The registered manager also lacked understanding of best practice in relation to the Mental Capacity Act by allowing the visual and auditory monitoring of two people at night without safeguards being in place.

The provider had sent out survey questionnaires to relatives, but had only received one response. The local authority told us they had also had difficulties obtaining the views of relatives but noted the views they had were more positive than 12 months previously. The provider told us they had run meetings for friends and family members of people at the service but could not locate paperwork to evidence this. Relatives we spoke with told us the service had improved in the last six months and there were more activities at the service. However, relatives also highlighted areas for improvement. Two relatives told us they thought the care was not as good at the weekend, and one relative told us they thought they were not always happy with the quality of agency staff used at the service. The provider told us they intended to gain the views of relatives but did not have a plan in place at the time of writing this report.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found an assault had taken place in May 2017 between two people living at the service that had not been notified to CQC in line with requirements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the inspection the provider took remedial action to address a number of the concerns highlighted as part of the inspection feedback process. Also, the provider could show us they had been continuing to address areas highlighted by their internal audits, all of which were encompassed within their action plan. Additional management support has been provided to the service and management arrangements are being reviewed at the service.

For example, regular checks of medicine stocks against records have now been undertaken. Staff training in behaviour management and incident reporting has taken place since the inspection; there is a specified safeguarding officer role being recruited to; and additional staffing for food preparation and cleaning has been provided at the service at weekends.

We were shown seven questionnaires completed by people at the service. The majority were positive about the service but four noted 'mostly' in relation to being understood and listened to by staff as opposed to 'always'. Four out of six people replied 'mostly' to the question related to whether there were plenty of activities at the service.

We could see from the minutes of regular residents' meetings that people had the opportunity to discuss things that mattered to them. This mainly related to activities that they wanted to take place and that some of these had occurred over the summer. The provider acknowledged there remained on-going work to get the views of people at the service and to evidence they were involved in how the service was run.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Reg 18(1)(2)(e) Care Quality Commission (Registration) Regulations 2009 The registered person had not notified the CQC of an incident where a service user suffered abuse or an allegation of abuse had occurred.

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 act in accordance with the 2005 Act as there were insufficient safeguards in place to warrant the audio and visual surveillance of two people at night. Regulation 11 (1)(2)(3)

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 Risk assessments were not in place to cover all risks identified which placed service users at risk of unsafe care. Reg 12 (1)(2)(a)(b) The provider could not evidence the proper and safe management of medicines. Reg 12 (1)(2)(g)

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 ensure effective systems were in place to prevent abuse of service users, and the provider did not act upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain securely and accurate and contemporaneous record in respect of each service user. Regulation 17 (1)(2)(a)(b)(c) The provider did not have effective systems to assess, monitor mitigate the risks and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b) The provider could not evidence they seek and act on feedback for the purposes of continually evaluating and improving such services. Regulation 17 (1)(2)(e)