Milewood Health Care Limited

Harlington House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 6 and 11 November 2014 and was unannounced.

At our last inspection of Harlington House in August 2014, we found that people were not always treated in a respectful manner and were not always receiving safe, consistent care and support. Furthermore the home was dirty and uncared for and people were not protected from the risks associated with medicines. We found there were not always enough staff working, and those staff were inadequately trained and supported. We also found that records were poorly maintained. The provider did not have robust monitoring checks in place, so had not identified that the service delivery had slipped and was inadequate. We issued eight compliance actions to the provider and told them that they must make improvements.

Summary of findings

We also required the provider to submit regular updates to us to demonstrate the improvements being made. Furthermore the provider agreed to not admit any more people to the home, until the improvements had been made.

This inspection was to check that the improvements recorded in the provider's action plan had been made. However, as we identified a range of areas where improvements were required at our last inspection, we carried out a comprehensive inspection at this visit, looking at all aspects of the service delivery.

Harlington House has been registered by Milewood Health Care Limited to provide accommodation and personal care for up to 17 people with a learning disability and /or mental health needs. People live in either Harlington House, which is a three storey older detached building, or Harlington Lodge, on the same site, which is a more modern building with communal areas and two floors. The Lodge accommodates six people, with the remainder being supported in small flats in the main house. It is located in a residential area south of York, close to local shops, community facilities and on a public bus route. There are parking facilities on the site.

The manager of Harlington House has been in post for less than three months. They have submitted their application to the Care Quality Commission (CQC) to be registered and on the day of our visit this application was being considered. 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 service has been without a registered manager for four months.

We found the service had made improvements to some, but not all areas where improvements were needed. The provider told us in their action plan that their recruitment and training programme would not be complete until December 2014. So we have not been able to report on this in detail, and will re-look at this next time we inspect the service.

We found other areas where improvements were still required. Records kept at the service were still not well maintained. Care records were not written in a way that was easily understood by people living there and did not identify important information, like the person's likes and dislikes, choices and interests. Important information was either missing or could not be easily located because of the way the records were managed and stored. This increased the risk of people receiving unsafe or inappropriate care.

We also found that whilst there had been some improvements in the way the service was monitored, further improvements were still required. This indicated the service was still not compliant, however, we noted the manager had not been in post very long. As a result we have decided to give both her and the provider more time to demonstrate that the new arrangements were making a difference to the way the service was being run.

We identified concerns at this inspection about the way the service recognised and acknowledged people's rights, when decisions were made about their care. Whilst the manager knew about the Mental Capacity Act and Deprivation of Liberty safeguards (DOLS) the staff we spoke with had no knowledge about this subject.

However, we observed staff were kind, friendly and helpful. The atmosphere at the home was more relaxed. Staff worked alongside people, helping them with tasks, rather than doing things for people. Staff asked people what they wanted to do and where they wanted to go. They listened to what people said to them.

The service was better organised and staff had a clearer understanding of their roles and responsibilities. Staff were more focussed in their work. As a result they had more time to spend with individuals and support people to do the things they wanted to do.

Staff were also supporting people to maintain their own personal hygiene. Records indicated that this was completed discreetly, in order to promote people's independence, whilst protecting their privacy and dignity.

People were supported to access and maintain healthcare support, though the records relating to meeting people's healthcare needs could be improved.

We found overall that the home was clean and well maintained and people were getting help from staff to maintain the cleanliness of their own rooms. This meant people were now taking some pride in where they lived and worked.

Summary of findings

People were receiving their medications appropriately and safely. The service had arrangements in place to protect people from the harm associated with the unsafe use of medication.

People were now receiving a more varied and balanced diet. The food cupboards and fridges were well stocked so people had choices if they wanted snacks or drinks during the day.

People overall told us they thought they and their belongings were safe. Staff were clear of their roles of identifying and reporting abuse. The provider took prompt action when abuse was reported. Having robust safeguarding processes helped to protect people from harm.

Whilst people were asked about the community activities they wanted to be involved with, these did not always happen as agreed. The records did not describe why the planned activity did not go ahead.

There was a new manager in post; however they needed more time to implement the changes they wanted.

People and staff and visiting professionals told us the manager had made a difference to the way the home was being run. They said the manager was approachable and available and staff were better organised and better led.

Overall the record keeping at the service was not good enough. This meant the service could not evidence actions they had taken, or evidence changes they had made as a result of events happening there. Care records were not person-centred. Other records relating to risk management and staff records were incomplete or missing.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the day to day staffing levels and the training provided to the staff team. Continued breaches were also identified in relation to the quality monitoring arrangements and record-keeping at the service.

We found a new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to assessing people's consent and mental capacity, when decisions about their care were being considered. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

There were not always sufficient staff available and in particular to support people away from the home with their interests and hobbies.

People told us they felt safe and the service had safeguarding procedures, including risk assessments to maintain people's safety.

Medicines were correctly stored and disposed of and records were well maintained. People received their medication as prescribed by their doctor.

The environment overall was clean and well maintained.

Is the service effective?

Requires Improvement

The service was not effective

Not all the staff had the skills and knowledge to support people appropriately.

None of the staff had completed any training around the Mental Capacity Act and Deprivation of Liberty safeguards (DoLS). Support workers we spoke with were unaware of legal processes to be followed, in order to protect people's rights.

People were given a choice of meals and there were a range of snacks and different drinks available for people. Some record-keeping in relation to people's nutrition could be improved.

People's healthcare needs overall were being met, although the record-keeping around this care required improving

Is the service caring?

Good

The service was caring

Staff knew about people's support needs and how they were to be met.

Staff spoke with people in a friendly, helpful and respectful way and listened to what people said to them.

Staff worked alongside people to help them complete tasks, in order to improve their life skills and independence.

People's privacy and dignity needs overall were respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

Summary of findings

Whilst staff knew about people's support needs, the associated care records did not show that this support was in line with people's preferences and interests or their life goals and aspirations. Records did not demonstrate that these choices were being kept under review.

Whilst people were supported in some instances to maintain contact with friends and families, other interests and community-based activities did not always go ahead as previously agreed.

Is the service well-led?

The service was not well led.

The overall quality of care records and other records about the running of the home required improvement. Written information was missing, lacking in detail, or difficult to find. The records did not indicate the staff group were well trained or well supported.

There was a new manager in post who was making changes however, there was no evidence of learning from accidents, incidents and complaints.

Inadequate

Harlington 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 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 took place on 6 and 11 November 2011 and was unannounced.

The inspection team was made up of two inspectors and one pharmacist inspector, all employed by the Care Quality Commission, and an expert by experience who was accompanied by a support worker. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert's area of expertise was in supporting people with a learning disability.

Prior to the inspection we reviewed the information we held about the service, such as information about incidents that happened at the service, which the provider has to inform us about and information shared with us by other agencies. We spoke with local authority commissioners and the learning disability community team to gather their views about the way the service was operating. Although the visit was a comprehensive inspection, we had not requested a Provider Information Return (PIR) as we had only recently inspected the service.

During the inspection we talked to six people who used the service, interviewed one senior worker and two support workers. We spoke with one visitor. We looked at the way medication was managed and we reviewed records, including three people's care records and two staff files. We also observed the way staff interacted and supported people and spoke with two visiting healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found the service was dirty and poorly maintained. People at that time were not living in a safe environment. We required the provider to get the service deep cleaned within three weeks of our visit. At this inspection we noted overall that the service was clean and had been mostly re-decorated since our last visit. Monitoring records about the cleanliness of the environment were well completed and people living there told us staff were more pro-active in helping them to keep their bedrooms and bathrooms clean. One person told us how the staff had helped them to change their bedding that morning. Since our last inspection the provider asked a healthcare professional with an expertise in infection prevention and control to inspect the service. The specialist sent us a copy of their report, which indicated the service had good management systems in place to minimise the risk of an infection outbreak.

At our last inspection we found people were not protected from the risks associated with medicines as the service did not have robust medication processes in place. However, at this inspection we found there were suitable arrangements in place for the safe storage and management of medicines. Medicines were administered by staff who had received appropriate training and had their competency assessed. There was a system in place to make sure that staff followed the home's medication policy and procedures.

Some people who used the service were prescribed medicines on an 'as required' basis. Individual protocols were in place for the use of these medicines and records seen showed that staff were following these protocols.

At the time of the inspection no person at Harlington House was prescribed controlled drugs. These are medicines liable to misuse. Although there was a controlled drugs cupboard in the home in case controlled drugs had to be kept, it was not secured appropriately in line with legal requirements.

When we inspected the service in August 2014 we found there were not always enough staff working. People we spoke with told us there were not always enough staff as well. At this visit we looked at the staffing numbers and saw that overall these had improved. Both people living there and staff spoken with, told us there were more staff working on most days and, as a staff team, they were better led and better organised. One support worker told us "When I first started I didn't think there were enough staff, but there are adequate staffing levels now."

We asked staff what happened if there was an emergency situation on a weekend or evening. Both they and the provider explained there was an out of hours on call system and senior staff were always available for advice, if needed.

The provider told us he was still recruiting new staff as the staffing complement was still incomplete. He told us in his action plan following the August inspection that the service would not be compliant to this area of care until mid-December as they continued to recruit and train new staff. Whilst we will re-look at this at our next inspection, the provider is sending us monthly updates about staffing levels and training plans, so we can continue to monitor this area. There is a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw the service had made changes to the way people accessed the Lodge since our last visit, to improve the safety and environment for the people living there. We noted there was now a keypad entry to the building, to help make the premises more secure, however we found the door did not always close properly, so the keypad was not always effective.

We spoke with people who lived at Harlington House about whether they felt they and their possessions were safe. One told us "Things are better now. Some 'old' staff had been unkind to me, but they don't work here now." People overall told us they were contented and felt safe though people living in the Lodge commented that they could not lock their bedroom doors, to ensure other people could not enter their rooms in their absence.

We did talk with one person who was given money each week by their relative. They told us they did not know how much money they had. They explained they had a lockable drawer in their room, but no key to lock it. We looked in their care records but could not see any records relating to their ability to look after their own money. Staff told us they were not involved in this aspect of support. However, without an assessment of the person's ability to take responsibility for their money, nor provision to keep this

Requires Improvement

Is the service safe?

money safe, then the provider was not doing all he could to keep this individual's property safe. We recommend that the provider provides people with the means to store personal items safely and securely.

We spoke with two support workers at Harlington House. Whilst neither believed they had attended safeguarding vulnerable adults training, both were clear about their role in keeping people safe. Both explained that if they had concerns about the manager's behaviour then they would speak with a more senior manager. They were able to give examples of potential abusive incidents that would need reporting. They also knew that all incidents needed reporting, even when they were asked not to tell anyone. This helped to ensure any allegations of abuse, or concerning information were reported in a timely way. We looked at the training records in relation to safeguarding vulnerable adults. These indicated that all except two members of staff had completed this training in 2014.

Information we hold about the service demonstrated that the provider had taken prompt action when allegations of abuse were reported to them, in order to keep people safe. They had notified the local authority safeguarding team and the commission in a timely way, as they are required to do by law.

We saw the service used risk assessments to help identify and manage the risk of harm to people. We noted these risk assessments looked at people's individual risks, as well as more general risks, that applied to all the people living there. We saw in some instances that these had been discussed with people, in that the individual had signed these records. However, those records we looked at were not dated so it was impossible to tell when these were last reviewed. Without dates the service could not evidence that these had been kept under regular review, or reviewed after an incident had happened, to check whether changes to the management of that risk were needed.

We spoke with two support workers about their recruitment process. They each told us they had to complete an application form, provide references and attend an interview. Both confirmed that they had a Disclosure and Barring Service (DBS) check completed, and were not allowed to start working there until these recruitment checks had done.

We looked at the recruitment files for those workers. We saw evidence that the recruitment processes were in line with the information given to us by those workers. Having robust recruitment processes helped to keep people safe. However, we saw the service used a template of set questions to ask at interview. This way of working meant interviewers did not ask individualised questions relating to the person's background or information within the person's application form. For example we noted one applicant had failed to record their start and finish dates of their current and previous employment on their application form. We saw no evidence that this omission had been discussed with them.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in August 2014 we identified concerns about meeting people's nutritional needs as we found there was not much food at the home. This meant there was minimal choice of snacks and drinks for people, and there was a reliance on people eating takeaway foods instead of home-cooked meals. We told the provider to take action to improve this area of care delivery.

At this inspection we found there were a much greater variety of foods for people to eat. There were fresh fruit and vegetables available and the cupboards and fridges were well stocked. We found menus were being written in consultation with people living there. One person said "The food has more variety now. We get an alternative if we don't like what's on the menu." Another person told us "My favourite food is salad. I had salad last night when everyone else had curry."

We spoke with one person living in the main house. They explained that they went food shopping and staff knew the kinds of food they liked. We saw there was food in their fridge and the individual showed us their bowl of fresh fruit that they could eat any time. We saw that people were now being weighed more regularly, to monitor their health and well-being; however the records we looked at, relating to nutritional risk management, did not evidence the actions taken when people lost or gained weight. This meant the service could not evidence that people's nutritional needs were being monitored and managed in a robust way.

We saw some information about the home was presented in a suitable format for people living there to read. We saw in the Lodge that the meal choices were written on a notice board each day. However we were also told some people living in the Lodge were unable to read, so this written information was of no value to them. The manager showed us photographs of different plated meals, but these were not being used. This meant the service had not taken into account people's individual needs when the service delivery was planned.

At our last inspection we identified concerns about the training and support provided for the staff team. Records did not evidence that staff were receiving an induction programme when they were first employed, to equip them with the skills and knowledge to support people safely. We told the provider to take action to improve this area of care delivery.

We spoke with two staff members who had started working at Harlington House in the past six months. They told us they had followed an induction programme when they started working at the service and had received one to one support from senior staff. They were happy with the support they received and thought the management team were available for them. They each told us of staff meetings they had attended. One referred to three meetings in the past six months. We saw the minutes from two of these meetings.

The training records held by the provider indicated that the two support workers had completed some induction training. However, when we looked at their staff files there were no records relating to an induction programme or supervision meetings. This meant that the service could not evidence that staff received appropriate training and support when first starting to work there.

We have reported on the quality of records kept at the service elsewhere in this report. The provider is sending us monthly updates to demonstrate the progress in ensuring staff have the appropriate skills and knowledge to support people safely and appropriately. This includes training to keep people safe, such as infection control, first aid, food hygiene, and fire safety, safeguarding vulnerable adults and managing challenging behaviours. The numbers of staff trained and up to date in these areas, from the provider's latest records vary between 35% for first aid training and 76% for fire safety training. We noted that much of this training had been completed in the last three months. We will continue to monitor progress with ensuring all staff are properly trained, as the provider told us following our last inspection that they would not be compliant in this area of service delivery until December 2014. This is a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we identified some concerns about how people's meaningful consent was gained, before care was provided. There is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Requires Improvement

Is the service effective?

2010. We looked at whether people's mental capacity was being considered when decisions were being made, in order to respect people's human rights and comply with the law.

We found the manager had some knowledge about the Mental Capacity Act (MCA) and the role of best interests meetings to determine choices for people when they were unable to make these decisions themselves. However, we did not see evidence of any best interests meetings in the records we looked at. We spoke by telephone with a healthcare professional, who consulted with four colleagues who had clients living at Harlington House. None of these professionals could recall being invited to a best interests meeting about any people living at the service.

We found the general manager had some knowledge about the Deprivation of Liberty Safeguards (DOLS). There was one person living at the home at the time of inspection subject to a DoLS. The service notified the commission appropriately of this application.

We asked two support workers about their understanding of the MCA and DoLS and the relevance of these rulings in care settings. Neither worker demonstrated any knowledge of this and said they had not had any training in this area. When we looked at the home's training records we saw that none of the staff had completed training in this area.

At our last inspection we found evidence that people at Harlington House were not always getting the care and support they needed to maintain their health and well-being. We told the provider to take action to improve this area.

On this visit we saw from looking at people's care records that the service contacted healthcare professionals for advice and support. One person told us "The staff keep me healthy." Another commented. "The doctor's is just across the road. Staff make an appointment for me when I need one." People's wellbeing was better monitored, although the quality of the records did not evidence the actions taken as a result of this monitoring. We found better evidence however, that people were being supported to maintain their day-to-day personal care, in a way that promoted their independence, but ensured they still managed this task to a satisfactory standard. We also observed that because staff talked with people in a more meaningful and person-centred way, then they were more likely to recognise that an individual was unwell, or troubled by something.

Two healthcare professionals were visiting people who lived at the service on the day of our inspection. They both told us that in relation to their area of expertise, they thought their patients were receiving the right care. They explained that people were attending their out-patient appointments properly and that a senior person from the home now always attended care review meetings, so these were now more valuable and relevant. This meant they could discuss people's care needs with a worker who knew the individual, and their support needs.

Is the service caring?

Our findings

At our last inspection in August 2014 we found people were not always treated in a respectful manner. People were not included in decisions made about their day to day care and staff did not value people's views and opinions. On this inspection we observed the way support staff spoke with, and generally interacted with people living there. We noted there was greater 'partnership working' than at our last visit. For example on this visit we saw one person preparing mushrooms and tomatoes for their breakfast. On our last visit the individual sat and waited, whilst the support worker prepared the breakfast for them. This way of working meant staff were supporting this person improve their independence and life skills.

We noted the atmosphere at the service was calmer and more relaxed. Workers spoke in a kind and compassionate way to people. They listened to what people said to them. People appeared more contented. When they talked to us about living there they told us about good things that had happened to them, unlike at our last visit when most of the people we spoke with told us they were unhappy and in some cases wanted to live somewhere else.

We spoke with people about the staff team. One person spoke fondly of one of the care workers, saying "She looks after me well and treats me nicely." They added though that some care workers were kinder than others.

We observed the way staff spoke with and generally interacted with people. We saw they encouraged and praised people and made suggestions about what activities could be done together. We saw the use of non-verbal communication, like touch and smiling to show they cared about people.

We saw some people had complex communication needs. The provider told us the staff rota was planned so that one individual always received support from a worker with whom they could communicate. We met that individual. Whilst we were unable to communicate directly with them, we saw the staff member working alongside the individual was able to communicate and reassure them about who we were and why we were there.

Staff told us they were working better as a team under the new management. They had a better understanding of how to support people and how to help promote their independence. They recognised the new way of working improved the outcomes for people living there.

We spoke with two visiting healthcare professionals and neither had observed any staff behaviours or attitudes in the past three months that caused them concern.

We observed mostly, that staff recognised people's bedrooms and/or flats as private, and knocked on the door, and waited to be invited in. However on one occasion, whilst talking to one person in their flat in the main house, a support worker walked through the flat, as a 'short-cut' to reach another person's flat. We discussed this observation with the provider who said they would look into this and take steps to ensure this did not happen again.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with who lived at Harlington House told us "Staff treat me alright" and "I can go to staff if I need help". One healthcare professional said "I think my client's needs are being met." A second commented "We're seeing slow improvement here. Staff are now working in a more person-centred way."

At our last inspection we found that although people at Harlington House had care records, these were disorganised and not always up to date. Nor were they easily accessible for staff to read, so they could satisfy themselves that they were providing the right care. We told the provider to improve their record-keeping.

On this inspection we found little improvement in the way people's records were organised, kept up-dated, or made accessible for staff to read. We found important information about people's care had not been recorded and daily/weekly/monthly monitoring records were not kept under review. The records we looked at did not indicate that people's care and well-being was being regularly reviewed.

In total we looked at three people's care records. We found they were not written in a person-centred way and we saw little evidence that people had been included and consulted about their care and support needs. Therefore although people and professionals indicated that care was becoming more person-centred, this was not reflected in their individual care records.

We saw little evidence of people's likes, dislikes, choices or interests. This kind of information was needed so that care and support could be tailored for that individual, so that they could live interesting and stimulating lives. People we spoke with gave us different views about their care records. Some people knew they had records and said they had looked at them. Others said they did not know of any care records. We noted that records were mostly signed by the individual. However, because these signatures and those of the staff were often not dated, it was impossible to know when all these reviews had taken place.

Those records we looked at were not written in a format that was accessible and meaningful to the people who lived there. There was no evidence that staff had talked with people about setting achievable goals to encourage and promote their independence. Nor did we see evidence related to promoting people's well-being, such as discussions around healthy eating or exercise plans.

We saw monitoring records were kept, but these did not provide good quality information about people's overall care and support. For example one person's care records indicated they needed help to keep their dentures clean and also needed cream applying to some parts of their body. Their daily records for the month of October did not refer to either of these aspects of care.

We noted on this visit that people were going out in to the community more. One person told us they liked going shopping with a support worker. Another commented "I go to a coffee morning each week and help with shopping sometimes. Staff go with me. I help to bring it in and put it away." We saw several people went out to the local shop with a support worker whilst we were there.

We noted a support worker put together a timetable of activities each week, in consultation with the individual. We saw these timetables in people's records. However, when we saw the completed records of their daily activities we found these bore little resemblance to the weekly one. So when people requested to go into town, or go for a walk, or go trampolining, then this hadn't happened. We saw there was a page to record why a planned activity had not happened, but we looked at two such records and neither had been filled in.

Accurate and well maintained records were needed to ensure people received safe, consistent care, as well as enabling the provider to demonstrate that the service was running well. This was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We asked people living at Harlington House what they would do if they had a concern or complaint about the service. Mostly people said they would tell someone if they were unhappy about something. One person though said they would "Keep quiet and not tell anyone." We saw the service had a complaints process displayed, and whilst this was in a pictorial format, to make it accessible for all the people living there it did not include pictures of the key people to speak with. However, all those we spoke with knew who was in charge and also knew the names of some of the senior managers who visited the service.

Requires Improvement

Is the service responsive?

We looked at the way complaints about the service were managed. We saw these records were not very detailed and there could be better evidence to show that staff had taken a complaint seriously and looked into it properly.

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2014 we found the service was not running well. The service did not have any robust monitoring arrangements in place, so staff had not identified that the service delivery had deteriorated.

We found on this inspection that the provider had introduced a number of monitoring checks. These included monitoring the cleanliness of the home and health and safety matters, including food safety checks. However, we noted these checks were not always completed within the timescales required. For example the records of the food temperature checks in October indicated that the temperature was not recorded on five of the days that month. There was no evidence that anyone had noticed these omissions or done anything about it. This demonstrated the service did not have robust systems in place to identify and action 'failings'.

We also saw that when issues were identified, then there was no evidence that actions had been taken to look into, and address the concern. For example a risk management action was to check the number of sharp items in the kitchen in the Lodge each day, to check that all could be accounted for. The daily checks of these in October totalled either 18 or 19, with both 18 and 19 recorded as 'all correct'. Whilst a support worker explained the reasons for this, there was no evidence that the discrepancy had been recognised and explained. Robust monitoring records were required to demonstrate the service was running safely and effectively.

The service did not have a system to learn from accidents, untoward incidents and safeguarding concerns. There was no effective system to continually review these incidents. There were no action plans to show what the service was doing to minimise the risk of similar events happening again. This meant there was no opportunity to learn from these events in order to improve the service provided.

One person told us house meetings had been held to discuss the running of the home. They explained "I never heard any more about what had happened after them." They added that they would like to know the outcomes. We did not see any action plans to show what changes the service had made as a result of these meetings.

We noted that a pharmacist visited the service in Spring 2014 and told the provider that the controlled drug cupboard did not meet with legal requirements. The pharmacist inspector identified at this inspection that this issue had not yet been rectified. This showed the provider had not responded to, or learned from feedback provided.

We also asked to see completed audits of the quality of the care records. We were told these checks had not yet been implemented, as other improvements had been prioritised.

Whilst we saw some improvements on this inspection we still identified some concerns around the way the service was being monitored. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that whilst senior staff had started auditing how the service was operating these processes were not well established. The new manager was implementing new systems and these needed more time to develop and become embedded.

The provider had appointed another manager since our last visit, though they had not registered with the commission. People we spoke with said they liked the new manager and said they were approachable and available for them. They commented "I like X. They are kind and they listen to me." Staff we spoke with also thought the service was improving and the new manager was providing good leadership and ensuring they were better organised. They told us "The home's better than it was. X has really made a difference." We spoke with a relative by telephone and they thought the new manager may bring about real change. They commented that for more than a year they had found it difficult to find out what was happening at the service, with their relative.

Despite the comments about the monitoring arrangements we found people were receiving better care and support. People were getting out into the community more. The service was cleaner, and the atmosphere was calmer. Staff were better organised and were consulting more with people about their day to day care and support needs. Health care professionals we spoke with told us the new manager had made changes to how the service was being run, to improve the culture of the service and the way staff spoke with, and generally interacted with people.

We also spoke with an environmental health officer who had visited the service. They too thought the new management arrangements had made a difference to the way the service was operating.

Inadequate

Is the service well-led?

As the service has improved its service delivery in other areas we have decided to provide more time for these monitoring arrangements to become better established and show they have been sustained and were making a difference to the way care was being delivered. We will look at the monitoring arrangements again on our next inspection to satisfy ourselves that the service is well led and responding to incidents and events in the home.

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 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitablequalified, skilled and experienced people employed for the purposes of carrying on the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained to deliver safe care and support to people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who used the services were not protected against the risks of unsafe or inappropriate care and treatment because the records were not accurate, were not kept updated and information stored within them was not easily located. Other records for the purpose of carrying on the regulated activity were not well maintained.

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 28 February 2015.