Psycare Limited

Winnett Cottage

Inspection report

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16 December 2015

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Winnett Cottage is registered to provide residential care for up 12 people living with mental health needs. At the time of our inspection 10 people were living at Winnett Cottage.

The inspection took place on 11 and 16 December 2015 and was unannounced which meant the provider did not know we were inspecting.

The home had a registered manager in post; 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 sufficient numbers of staff were deployed to provide care to people living in Winnett Cottage. The registered manager had not reviewed and investigated all incidents and accidents to keep people safe from the risk of harm or abuse. Risk assessments had not always been developed to positively manage risks to people. People's medicines were stored safely and information was available to staff about how to manage medicines, however this information was under development. People were supported by staff who had undergone a robust recruitment process which ensured they were of sufficiently good character to provide care to people.

Staff felt supported by the manager which enabled them to carry out their role effectively. Staff had received training relevant to their role. People's nutritional needs were met and monitored where required. People were able to freely choose what they ate. People's weights and dietary records had been maintained where needed. People we spoke with told us they had access to a range of health professionals, and records demonstrated they were referred quickly when their needs changed, which was confirmed by visiting professionals.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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 in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was working in accordance with MCA requirements.

Staff spoke to people in a kind, patient and friendly way; however people told us that the responsiveness of

staff varied. Staff consistently ensured people's social needs were met; however people did not always receive care that was responsive to their needs.

People did not always receive high quality care that was well led and people's care records were not stored securely. People's views about the quality of service they received had been sought, however these had not prompted a review of the service provided in order to see how improvements could be made. The manager had reported untoward incidents to the local authority, however not to CQC as required.

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 consistently safe.

Untoward incidents that took place were not consistently managed.

People's identified risks such as behavioural, had not always been robustly reviewed and assessed.

People told us they felt there were sufficient numbers of staff available to support them.

People's medicines were stored and managed safely and people were supported to take their medicines independently where possible.

Is the service effective?

Good

The service was effective.

People told us that staff were suitably trained and had sufficient skills to support them.

Staff had received training in a range of different areas relevant to their role.

People told us that staff gained their consent prior to assisting them with tasks.

Where required assessments of capacity had been carried out in line with the requirements of the Mental Capacity Act 2005 and people were not unlawfully deprived of their liberty.

People had access to a range of healthcare professionals to support them where their health needs changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported by staff who were proactive in building positive relationships to support their wellbeing in a

caring and meaningful way.

People were able to influence or contribute to their care through discussion with staff.

Staff spoke with people in a kind and sensitive manner and ensured people were treated with dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was responsive to their needs.

Care plans were person centred and included areas around people's likes, dislikes and interests. However they lacked specific details about managing behaviours that challenge.

People told us they were aware of how to make a complaint. However, complaints we looked at had not been thoroughly investigated. People were not provided a forum to raise comments or concerns about the quality of care or living in Winnett Cottage.

People were encouraged to be part of the wider community and pursue interests and pursuits.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Statutory notifications that are required to be sent to the commission had not been made.

People's views and opinions about the quality of service they received had been sought, but did not prompt a review of the quality of service.

The provider had systems available for the manager to review and assess the quality of service, however they had not utilised these as required.

People's records were not held securely.

Winnett 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 11 and 16 December 2015 and was unannounced. One inspector carried out the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires the provider to give some key information about the service, what the service does well and improvements they planned to make. We also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

Prior to the inspection we spoke with a member of the contracts monitoring team for the local authority. During the inspection we observed staff support people who used the service, we spoke with three people who used the service, three members of staff, and the registered manager.
We reviewed care records relating to four people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Winnett Cottage. One person said, "Yes, I feel safe, I can come and go as I want and I feel happy."

Staff we spoke with were able to describe to us what constituted abuse and what signs they looked for when supporting people. There was a range of information available to people, staff and visitors informing them how to report their concerns. Information for external agencies such as CQC or the local authority were prominently displayed where people could also raise their concerns.

Staff we spoke with were aware they could report their concerns to both the local authority and CQC and were clear about their responsibilities around whistleblowing. The provider had arranged for an independent organisation to provide a confidential whistleblowing helpline for them to contact. Staff spoken with had no hesitation in telling us they would immediately report any incident or conduct they felt was abusive. One staff member told us, "Where I worked before I contacted CQC, and I would do it again if I had to."

Untoward incidents that took place in the home were not consistently managed. We reviewed the incidents log and noted that some incidents identified in people's daily records had been reported to the manager but had not been sufficiently reviewed. For example in one person's daily records staff had observed them bringing illicit substances into the house. We saw that the authorities were informed but took no further action in relation to this. However, the manager had then not reassessed the likelihood of the incident recurring, or taken preventative steps to mitigate this risk.

We noted numerous examples throughout the previous 12 months where people had either used or allegedly brought illicit substances into Winnett Cottage. We saw that an incident had occurred where staff were told by a person that another resident was supplying illicit substances within the home. Staff confronted this person and reported the matter to the police, however did not take immediate action to safeguard the other people living in the home. The matter went unreported to CQC or safeguarding. We asked staff what actions they took to protect people from the risk of harm, they told us, "We were going to raise a safeguarding report but [Person] left two days after the event." Other people living in Winnett Cottage were identified as being at risk of harm through exploitation. By not acting swiftly to report the incident to CQC and safeguarding teams meant that people remained at risk of harm or exploitation because the manager did little to ensure people were protected from the harm associated with illicit substances in the home.

We asked the manager if they had reviewed the incidents in order to better understand the trends emerging, particularly in relation to illicit substance misuse as required by the provider's policy. They told us they had not. Where these incidents had identified concerns around the misuse of illicit substances, they had not triggered the manager to consider how they may interact with prescribed medicines. They had not discussed this with the prescriber or psychiatrist, and had not referred people to specialist services for support with substance misuse.

Minutes of a regional managers meeting we saw from October 2015 had an action point that all managers were required to review their incidents. We saw the manager had not completed this and asked why they had not done so following the meeting. They told us that a new format was had been provided to record and review incidents which looked at themes and lessons learned, however they had not used at the time of the inspection.

Where incident reports were completed, they lacked evidence of how the matters were followed up, or how staff would mitigate future risks recurring. For example, one report documented "At around 12am – [person] was in [person] room. When they came downstairs they were told by staff to not be in each other's rooms. [Person] kept silent. [2nd person] then went on the verbally abuse staff. The next day [person] reported their events of what happened to [staff member]. There was no further elaboration or investigation recorded in the report. There was no evidence of actions taken, or how each person's risks had been reviewed. We had to ask staff to recall the incident from memory, which was that one person, had been extorting money from a second person. This person had been identified as at medium risk of exploitation, however this did not prompt a review of their care. This incident was reported to CQC and the local authority as required.

This meant that people were not always protected from harm or unsafe treatment because a system of reporting, reviewing and identifying risks to people was not robust or consistent. We have informed the local authorities commissioning and safeguarding teams of our concerns.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had not ensured that identified risks were documented and managed through robust care planning. For example, one person had a risk assessment completed in September 2015 by the manager. This identified several areas of concern including history of violence and aggression towards others, and also of hearing command and auditory hallucinations. There were no available care plans that documented clearly the nature and type of hallucinations the person heard, or how staff could support them when they suspected they were experiencing these. We saw that the last time this persons care needs were assessed by a multi-disciplinary team was in February 2015 whilst resident at another home. Since then their needs had changed, they had moved and a meeting with their Mental Health Services Co-ordinator had not been arranged. Furthermore, we were unable to find any risk management plans in relation to how to support the person should they suffer a deterioration of their mental health. Care records did not provide staff with a clear picture of potential signs, indicators or triggers. One person who had displayed violence and assaulted females previously did not have a care plan in place to identify and manage these risks. When we asked staff about the person's triggers they said, "Frustration around their emotional and sexual feelings would be a trigger for them, they would grab females, but we have ensured that they don't have one to one sessions with female staff." No other guidance was available for staff to identify how to support the person or for staff to remain safe.

We saw that for one person, a risk assessment had asked the assessor, who was the manager, to consider, "The residents perception of their needs." Within the assessment of need dated September 2015 staff recorded that, "[Person] does not believe [Person] is mentally ill." However, in the actions section of the same plan, the manager had written that, "[Person] agrees to develop insight into mental health problems." When we looked further at the care plans there was no evidence or treatment plan available to demonstrate to us how the person would carry this out.

The lack of appropriate risk assessment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were sufficient numbers of staff available to provide their care and support. One person said, "There are now enough staff to help when I need them to, it's been better since [staff members] started." The manager told us they had recently experienced difficulties with staffing numbers as two staff members had left the home, and they found it difficult to recruit. They said that they had used agency staff, and although this had not been ideal, as some of the workers did not specifically have training in Mental Health services, they had managed to meet people's needs. However, we saw that they had successfully recruited two new staff members who were undergoing their induction. We observed that people were responded to when they required support and did not have to wait for an unduly long period.

People's medicines were stored and managed safely. People were supported to take their medicines independently. We saw that assessments were carried out and reviewed by a doctor, who determined if people were able to self-administer. People then kept their medicines in their rooms, and were free to take these as prescribed. Staff carried out a number of spot checks to ensure that people took their medicines as prescribed, and where they felt people were at risk of not taking their medicine, they then administered these from the office until the person was stable once again.

Stock checks of medicines we looked at in the office were correct, as where the stocks of medicines in people's rooms. We saw that in addition to these checks the pharmacy that provided people's medicines carried out their own audit. Where actions were identified these had been completed.

Medicine records we looked at had been completed when people's medicines were administered to them, and were reviewed when required by health professionals. Policies were in place in relation to the use of over the counter medications such as paracetamol and indigestion remedies, and the manager was in the process of developing a suite of information sheets for side effects for prescribed medicines.

At our previous inspection we found the carpets in the lounge and outside the toilet were badly stained and there was no cleaning schedule which ensured that all areas of the home were cleaned regularly. At this inspection we found the manager had implemented a cleaning rota in the home, that people who lived there carried out, which was then supervised by staff. They had replaced the flooring in the lounge and toilet areas, and where a further carpet required replacing the manager had taken action to order this prior to our inspection. On the second day of our inspection the home was undergoing renovation and contractors were in the process of repainting areas in the home. Throughout our inspection the home was clean, odour free and welcoming. We saw that staff were provided with personal protective equipment, such as gloves and disposable aprons to protect against the risk of cross infection and staff had attended training in the prevention and control of infection.

Good

Is the service effective?

Our findings

People we spoke with told us they felt staff were sufficiently well trained to carry out their roles. One person said, "Yes the staff are brilliant, always there when I need something." Staff we spoke with told us they felt supported in their role by the manager, one staff member said, "[Manager] is really hot on supervisions, they are the best manager I've ever had."

Two new staff members we spoke with told us they underwent an induction that involved them meeting the people they would support and read and understand people's care records. They said they spent time shadowing experienced staff until they got to know people, and then until the manager felt they were competent to provide one to one support. They told us that during their induction the manager met with them regularly and was available daily to discuss their progress. One staff member said, "Induction was really good and helped me to settle in and get to know how things work in Winnett."

Staff told us that they received training in a range of areas such as safeguarding, mental capacity and medicines administration. The training matrix confirmed that staff had received this training and it was in date. Staff were supported by a manager who met with them regularly to discuss their performance and any issues they required support with, or to look at ways to develop their role. One staff member had expressed an interest in supporting the manager in amore hands on role and had been given responsibilities within the office, working with the manager to develop the records and care plans for people. We were told by one staff member, "[Manager] is so supportive, and encourages us to put ourselves forward to help us develop in different areas."

Staff were observed to seek people's consent on numerous occasions prior to giving support to them. People were asked if they needed help with cooking or wanted to eat, or if they were ready to bathe and get changed. When people said they were not ready to do so, staff were seen to acknowledge this and return at a later time and once again prompt people to manage their needs. This showed us that staff took the time necessary to explain what they needed to do, but waited until the person was ready to provide their consent.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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 in line with the principles of the MCA. At the time of our inspection, no people living at Winnett Cottage were considered to lack capacity. One person had been

identified as possibly lacking the capacity to manage their finances, however they had been referred to the local authority and assessed as having capacity to make these decisions.

Staff we spoke with were aware of their responsibilities towards assessing and supporting people who may lack capacity and had received training to support this. There were no instances where people were deprived of their liberty or restrained in any way, people were free to come and go as they pleased, and staff understood their responsibilities around restraining or depriving people of their liberty. In some instances, some people may be subject to a community restriction order, which is part of the Mental Health Act 1983 legislation. In some circumstances people may live at Winnett Cottage following a period in hospital following ill health or due to a forensic history where treatment was ordered as opposed to imprisonment. People returned to the community following a period in hospital, however restrictions would be placed upon them to ensure people were kept safe. we reviewed one of these orders and found that this restriction had been discussed and agreed with the person, and the manager regularly reviewed the order to ensure the conditions were met.

People were supported to plan, prepare, cook and eat their meals. Staff continually encouraged people to eat a healthy meal. One person had said they wanted to eat only microwave meals and nothing else, however staff had gently persuaded the person to begin to cook alternatives for themselves. This person told us, "They are slowly getting me to eat healthier things, I prefer the easy meals but know I need to eat fresh cooked meals to stay healthy."

People who were at risk of weight loss were monitored regularly by staff. Staff ensured they completed MUST assessments to identify where people may he at a high risk of weight loss, and took action to mitigate this where necessary.

People told us that if a person's health deteriorated then they were referred quickly for support. Records we looked at demonstrated that a range of health professionals were involved in people's care including GP's, district nurses, community psychiatric nurses, mental health crisis teams, dentists, opticians and dieticians where needed. During our inspection we observed on several occasion people asking staff to support them with a range of appointments including the dentist and GP.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they felt the staff were at times caring and attentive. One person said, "The staff are great and helping me with what I need and are on hand all the time." A second person said, "Some are helpful, some just don't care."

The manager explained to us that there had been changes within the staff team recently, which had resulted in them using agency staff which ensured people were supported where needed. Staff that had left had been long standing members of the team, and had built positive relationships with people who lived at Winnett Cottage. The manager told us they had recently recruited two new members of staff, who were enthusiastic and committed to people who lived at the home However they also acknowledged that the recent staffing issues had impacted on the quality of care provided. They told us that as a result they had worked excessive hours to try to bridge the gap and maintain stability in the home.

We observed throughout our inspection that staff interacted with people in variable ways. People we spoke with confirmed that the relationship with staff varied from day to day. One person for example told us that not all staff were as attentive or supportive of them. They said, "[Night worker] just comes in and sits and watches TV, they're not as helpful as they day staff." We saw over the course of our inspection that different staff adopted a different approach to people. On the first day of our inspection, both staff were seen to be in the office, with the door closed and responded to people only once they had knocked on the door for assistance.

On the second day, we saw a more positive approach where staff were more proactive and positive in the way they interacted with people. Staff on the second day spent time in the home with people, talking to them and understanding how they were feeling at that particular time. If there were concerns or anxieties that people had, the staff on duty were seen to spend time with the person, listening to their concerns and exploring options. People we spoke with told us they preferred staff to be more visible and approachable in the home. One person said, "[Staff members] are new but they go out of their way to be friendly and sociable with all of us, checking we are okay and if we need anything." A second person said, "They have had staff come and go, some were better than others, but we didn't build a relationship with them." We spoke with the manager and suggested this is an area that requires improvement. They acknowledged that staff had not always been proactive in supporting people's wellbeing in a caring and meaningful way, or responding to their needs quickly enough to identify and relieve people's distress or discomfort.

People told us they were able to make choices about the way they spent their day, and were supported to remain independent. They said that staff spoke with them about their day, how they planned to spend it, and made suggestions of how they could productively spend their day. People were encouraged to clean and tidy their rooms, prepare and cook their meals, and manage their finances. Some people chose to spend time with staff who assisted them with shopping and chores and others chose to visit the local town. One person said, "We are free to come and go as we like and the staff are always on hand to talk to for advice or support." A second person told us, "I have made videos of me with my birds, and [staff member] showed a real interest in what I was doing, I'm waiting to get some more equipment so I can carry on with

it."

People and staff told us that they had regular key working sessions. This was a forum that meant people's support needs were discussed and reviewed, and an agreed plan of care was developed. In records that we looked at, we saw staff had discussed with people areas that were important to them such as their social networks and relationships. Where possible staff supported people to maintain these networks that were important to them. For example, one person told us how they were free to have visitors to Winnett Cottage and how they were being supported to visit family at Christmas. People we spoke with told us that staff kept them informed of changes to their day to day care needs, such as reviews with doctors or social workers and medical appointments.

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at that related to personal care matters and social activity were person centred and contained information with regard to likes and dislikes activities of daily living, for example washing, bathing, eating, drinking, sleeping, and in one example a person's mobility needs. The care plans when completed documented how the person wished to receive support for each of these identified areas, indicating which they were self caring for, which they required assistance and which they needed prompting for.

However care plans that related to mental health matters were basic. For example, where people displayed behaviour that challenged, or who were prone to suffer low moods, their views had not been sought on how to manage this or how staff were to intervene.

Where people had been identified by the manager as being at risk of exploitation, either emotionally or financially the care plans did not provide guidance for staff about how to identify, respond to and protect the individual concerned. When we spoke with staff two of whom were newly appointed to the role, who supported people in these specific areas they were unable to demonstrate to us sufficient individual knowledge of the person's needs. For example, one person who had displayed aggressive and violent behaviour towards others did not have an assessment or plan in place of how to manage this. Staff at the time of inspection were not sufficiently aware of the person's history, or how to spot any triggers, and did not describe to us a consistent method they would use to intervene and support the person when they required this.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they knew how to make a complaint if they wished to or raise concerns about the quality of care they received. There was information available to people and visitors about how to make a complaint. A copy of the provider policy was prominently displayed, and also gave the details of organisations that people could escalate their complaint to if not satisfied with the response. However, we found that complaints raised had not always been thoroughly reported or investigated. We found whilst reviewing the daily records for people in the home that four complaints had been raised. These had not been documented as a complaint or recorded, investigated and responded to by the manager.

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to engage in social activities, and develop their social skills to avoid isolation. People were seen to be listening to music, shopping, reading and talking to one another throughout our inspection. Wherever possible, staff actively encouraged people to assist in the running of the home, particularly at meal times. People who were less able to cook for themselves shared the cooking tasks and staff were on hand to supervise this.

People who lived at Winnett Cottage were encouraged to be an active part of the wider community. For example each day people were able to go to the local shops, on outings to local towns, and had access to a range of further education opportunities. Information was available in the home for people to access college courses if they so wished, and also for responsibilities in the home that enabled them to develop skills.

However people were not always however able to share their views on the running of the home, or share any comments or suggestions. The manager had introduced a 'House meeting group' once a month to be held from 4 o'clock. People we spoke with had not attended a house meeting for the previous twelve months, and staff we spoke with told us this was because it was held at a time when people were not all available to attend. When we asked the manager for copies of minutes they said, "I don't know where they are, the minutes were being typed up by [Staff member] and I don't know what [staff member] has done with them. I hope they haven't shredded them. However, one staff member we spoke with told us they had recently been asked by the manager to arrange the meetings for a different time, and to recommence these shortly. At the time of the inspection these had not occurred, but this staff member was clearly excited by this opportunity, and told us they further planned to incorporate a house meal where people would be able to cook and eat as a community, and discuss house related matters and concerns at that time.

Requires Improvement

Is the service well-led?

Our findings

Statutory notifications that are required to be sent to the commission without delay had not been made. When we reviewed the incidents log for Winnett Cottage we found five incidents that had been reported to the police and local authority for incidents that involved people who lived at Winnett Cottage. However, even though the manager had reported these to other agencies, they had not informed CQC as required.

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

The views and opinions of people who used the service had been sought in relation to the care they received. We looked at the recent results and noted that although the initial results were positive the manager had not undertaken any form of analysis to understand the feedback, or how they were able to further improve the quality of service people received.

The provider had systems in place to audit and monitor the quality of care people received. These included areas such as medicines, health and safety, complaints, incidents and safeguarding and staff training. However, we found that audits were not always completed when they were required to be. We saw that monitoring and reviews of complaints and incident reported had not been carried out. This resulted in concerns or complaints being noted in daily records but not addressed or identified by the manager. Incidents had also been documented in a daily record, but then not forwarded to the manager for investigation and review. The manager had not looked at patterns or trends that arose from the incidents that staff had recorded which indicated people were not always protected from harm.

The provider or manager did not have a service improvement plan available that identified, addressed and remedied concerns. We asked the manager if senior management carried out formal reviews of the quality of service provided, and checked which ensured that identified actions were completed. They told us that their line manager carried out reviews regularly, however they did not have copies of these reviews available for us to review. The manager submitted copies of these reviews shortly after the inspection took place. However these did not address a number of the issues identified during the inspection. We saw from minutes of the managers meeting that the regional manager had asked all managers to ensure their incidents were regularly reviewed. They had done this in response to inspection findings at other locations. This was seen in meeting minutes from October 2015. However at subsequent visits to Winnett Cottage, the incidents were not checked to ensure they had been assessed.

We looked at the reviews carried out for October, November and December 2015. Each contained very little detail about what areas had been reviewed. We saw that on each visit, a discussion had been held with the staff and manager, and a brief record made. Each visit was recorded on a one page sheet that identified Staff, Residents, Facilities and Other areas to review, but with no guidance in order to direct the assessor. Where an issue arose, it was documented, but no action plans were put in place to review or monitor these. For example, in October 2015 it was noted that, "Files in process of being reorganised." However in November 2015 this issue had not been reviewed further. The systems in place to review and monitor the quality of recording in people's records were ineffective in identifying gaps in recording and did not seek to

remedy these in a timely manner.

People's records were not held securely. Although records we looked at, particularly daily records were concise and well written, the manager and staff had not ensured these were stored safely. During our inspection, the manager was unable to locate many documents required for us to review, such as minutes of team meetings, house meetings and other associated audits or files. They told us that they were concerned a person had removed records from the office. In a copy of the providers visit, we saw on 11 November 2015 that the manager told their line manager they were concerned that copies of files had gone missing. On 15 December 2015 they had once again raised their concern that materials had gone missing from the office. However, we were unable to see where the manager had carried out any form of investigation to identify where the records had gone. Subsequently records that related to the care people received and management of the service were not held securely. This demonstrated there was not a robust and systematic method of reviewing, assessing and responding to concerns that may affect the quality of service provided to people.

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 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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) (f) Incidents that had been reported to the police had not been notified to the Commission as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) 3 (a) (b) Care plans did not reflect the identified needs of people and had not been completed collaboratively with the person who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) Systems and processes were established but not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2) Complaints when received had not been investigated objectively and where necessary proportionate action had not been taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) The manager had not assessed, routinely monitored and where necessary improve the quality and safety of the services provided . Untoward incidents which placed people at risk of harm had not been robustly monitored and assessed to keep people safe. Records relating to the management of the home and care of people were not held securely.