Hothfield Manor Limited

Hothfield Manor Acquired Brain Injury Centre

Inspection report

Bethersden Road
Hothfield
Ashford
Kent
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Ratings

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

Overall summary

This inspection took place on 29 and 30 December 2015 and was unannounced.

Hothfield Manor Acquired Brain Injury Centre provides accommodation with personal and nursing care for up to 45 adults with an acquired brain injury. The service is divided into three areas. The Neuro-Rehabilitation Unit provides short term specific rehabilitation; the Manor House provides long term care; and seven Bungalows within the grounds provide support for people who are able to live more independently. At the time of the inspection there were 31 people living at the service.

There was not 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager (who had worked at the service for 18 months) had taken on the role of acting manager and had been in this current post for six weeks. They were present on the days of the inspection.

People's safety was being compromised in a number of areas. The arrangements that were in place to safeguard people from the risk of abuse were not adequate as people were frequently suffering harm and not all incidents which should be reported to the local authority and CQC had been. The management of risks relating to people's health conditions and challenging behaviours were inadequate. This put people at risk of serious harm. Staff did not always understand risk and accidents and incidents were not always recorded and analysed to reduce the risks of further events.

There were not enough staff at all times to meet people's needs. Recruitment procedures did not ensure that staff employed had the necessary skills and were suitable to work with people. Not all staff had received the necessary training and some training was out of date. There were no systems in place to support staff appropriately, identify their development needs or to check they had learnt from the training. Staff did not always treat people with dignity or respect.

People were not consulted about their care and treatment and were not involved in their care plans. Care plans lacked information about people's interests and preferences. They were not maintained and did not always reflect the needs of people. People could not rely on care being delivered in a consistent and appropriate way. Where assessments of people's needs were required they had not always been undertaken. Activity provision was inadequate and people had very little engagement and were at risk of social isolation.

Medicines were not consistently managed safely, handled appropriately, stored safely and securely or disposed of in line with guidance. The provider had a policy in place but staff had not consistently adhered to this. The service was not clean and tidy and was not free from offensive odours.

When people were unable to give valid consent to their care and support, staff did not consistently act in people's best interest and in accordance with the requirements of the Mental Capacity Act (MCA) 2005. Some staff did not understand or have a good working knowledge of the key requirements of the MCA and how it impacted on the people they supported.

People's health was not consistently monitored and care and support were not consistently provided to meet any changing needs. Staff did not always know what to do to make sure people had everything they needed.

People's views on the food varied. The food looked appetising; people ate well and took the time they wanted to eat their meal. Staff took into account people that wanted to eat alone or in their own room.

The provider had a policy in place which gave guidance on how to handle complaints but information given to people included out of date information about who to complain to. Staff were concerned about the quality of the service being delivered. Staff told us they did not feel supported or valued by the management and were not clear about what was expected of them.

There was no clear auditing system in place to monitor the quality of the service being delivered. Records were not in good order or always kept up to date. Records were stored securely to protect people's confidentiality. Notifications about important event that had happened at the service had not consistently been submitted to CQC in an appropriate and timely manner in line with CQC requirements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent

Summary of findings

enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

The service was not safe.

People were not protected from the risks of avoidable harm and abuse. People did not always receive their medicines safely and on time.

Care plans and risk assessments did not give staff sufficient guidance on potential risks and how to minimise risks to keep people as safe as possible. Accidents and incidents were not always recorded and were not regularly analysed to reduce the risks of further events.

The provider had recruitment processes to make sure that staff employed were of good character but there were gaps in people's employment history which had not been explored. People were not supported by enough suitably qualified, skilled and experienced staff to meet their needs.

Is the service effective?

Inadequate

The service was not effective.

Care plans had not been written with people and their relatives.

Only 40% of staff had completed training on the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff did not consistently acted in people's best interest.

Staff had not completed regular training and the provider had not ensured that staff had one to one supervision and appraisals to make sure they had the support to do their jobs effectively.

People were provided with a range of foods and drinks. The building and grounds were not suitable for people's needs.

Is the service caring?

Inadequate

The service was not caring.

Staff did not understand or respect people's preferences and individual needs. Staff did not always treat people with dignity and respect. Some staff were caring, compassionate and patient, allowing people time to respond.

People and their representatives were not involved in the planning, decision making and reviewing of their care.

Staff understood the importance of confidentiality and knew how to protect people's personal information. People's records were stored securely to protect their confidentiality.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always contain sufficient and up to date information about people's needs to allow staff to deliver care in a responsive and personalised way. Where assessments were needed they were not always conducted.

Summary of findings

Staff did not always have good understanding of people's needs and preferences. There was a lack of activities available to meet people's individual needs. The culture and routine of the service was task orientated and not visibly person-centred care.

There was a complaints system so that people and their representatives knew how to complain however it was not effective and information on the notices was out of date.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership in the management of the service which had an impact on people, staff and the service provided.

Staff told us that the service was not well led. The staff team did not work closely or communicate well.

Staff were not committed to providing consistent, person centred care.

The system used to assess and monitor quality was not effective. Regular audits on the quality of the service had not been completed. Previously highlighted shortfalls had not been consistently recorded and acted on.

Hothfield Manor Acquired Brain Injury Centre

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 29 and 30 December 2015 and was unannounced following receipt of information of concern. The inspection was carried out by one inspection manager, four inspectors, two specialist advisors, who both had clinical knowledge and experience of working with people with acquired brain injury, 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.

The provider did not complete a Provider Information Return (PIR) because CQC did not request one before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We asked these questions during the inspection. We reviewed information we held about the service. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when a significant events happen, like a death or a serious injury.

We looked around all areas and grounds of the service. We spoke with over 15 people living at the service. We spoke with more than ten members of the care team, the acting manager and the hospital director. During our inspection we observed how the staff spoke with and engaged with people.

We looked at how people were supported throughout the inspection with their daily routines and activities and assessed if people's needs were being met. We reviewed care plans and associated risk assessments. We looked at a range of other records, including safety checks, staff records and records about how the quality of the service was monitored and managed. We requested that the provider send CQC further information following the inspection which was submitted in a timely manner.

We last inspected Hothfield Manor Acquired Brain Injury Centre in September 2014 to follow up on previous concerns about the management of medicines and assessing and monitoring the quality of service provision and found the service to be compliant.

Inadequate

Is the service safe?

Our findings

Although people told us that they felt safe living at Hothfield Manor we found that people were at risk of harm and were not protected from the risks of avoidable harm and abuse. Comments from people included, "I do feel safe here. I know the office is next door and I have locks on my doors to keep me safe" and "It's very safe. I'm afraid of the dark so they leave a small light on until they know I'm asleep". A member of staff commented, "There is not always enough staff to meet people's needs safely".

Staff were not knowledgeable about how to ensure people were safe. Although the provider had a policy for safeguarding adults and this gave staff information about preventing abuse, recognising signs of abuse and how to report it, staff told us that they had not completed regular training on safeguarding and were not sure how to apply the policy. Only 65% of staff had completed training on safeguarding vulnerable adults. The service used a high number of agency staff. Their skills and knowledge about safeguarding people were not sought prior to them working at the service. A member of agency staff told us that they were "not really sure of the services safeguarding policy".

People's safety could not be assured and people were at risk of harm from others. People living in the Manor House had experienced a number of physical (including sexual assault) assaults and verbal abuse. There had been a number of incidents between people and some had resulted in injury. These concerns were not consistently raised with the local authority and the Care Quality Commission which meant that outside agencies had no way of knowing about these incidents and therefore could not provide the right support to the service or the people at risk. Despite the level of incidents at the service the acting manager told us that there were no people living at the service who would display behaviours that may challenge others, however, we established that this was not the case and saw records which showed that people used violence and threatening behaviour towards other people and staff. This included intimidating verbal language and physical assault.

Staff did not always understand the potential risks of harm to people and when they did, risks were not well managed. For example, an incident which had happened on 3 December 2015 was recorded as follows: 'I was cleaning apartment 1. One of the clients had been cooking but had left the area. I was aware that the hob was hot. And I was concerned for the safety of one of the clients as she was walking around the unit and I didn't want her to come to any harm. I spoke to one of the therapists to let them know that the client may be in danger. Their reply was 'shut the door then'. I remain concerned as any client can open the door and may not have the insight that the hot hob is a danger to them'.

Some people were unable to make informed decisions about any risks they may take so staff assessed risks on their behalf. Risk assessments varied in content and there were different systems of assessing risk. Some were completed on paper and some were tick boxes on a computerised system. Identified risks were not consistently incorporated into care plans. For example, one person had been identified as low risk; however, there were no risk assessments in place for the identified risks of this person of refusing medicines, their catheter care, behaviours that may challenge others or wanting to leave the service to live in their own home. This did not ensure the person was supported to keep safe. Staff were not aware of any process to address the risk of people refusing their medicines. Staff did not know how long they would wait before contacting a GP. One person had a course of antibiotics and, although the records noted that the course had been completed, this person had refused their medicines on five occasions and only 12 of the 14 tablets had actually been taken.

There was an 'understanding behaviour guidance' document dated 23/06/2014 which had been signed by one member of staff as being read. Another document, 'recording challenging behaviour' was dated 07/05/2014 and had been signed by four staff. Neither had been reviewed or updated.

People were not supported to keep safe and did not consistently have risks assessments in place for when they went out. For example, one person spent the night away on 29 December 2015 but did not return at the agreed time. This person's care plan noted that when they were out on long visits staff should establish a contact point about mid-way and contact by phone to ensure that all was well and that they were safe. Staff told us that they were not aware of this and did not contact them until prompted by a Care Quality Commission inspector. The person did not return to the service until 13:50 and staff had not kept in contact with them. Another person often went out early to

Inadequate

Is the service safe?

go to the shops and didn't let staff know they were going out. Staff told us that if the person wasn't there they '"presume he has gone to the shops". There were no systems in place to check and monitor that this person was alright and returned safely.

Fire exits in the building were clearly marked, fire alarms were tested to make sure they were in good working order and regular fire drills were carried out. Staff who were supporting people in the Bungalows told us that they did not know whether they should evacuate people or leave them in their Bungalows should there be a fire or other emergency. Staff said they did not know where they should go if the alarm sounded.

When accidents and incidents happened they were not always reported, by staff, to the acting manager who was responsible for ensuring appropriate action had been taken to reduce the risks of incidents happening again. This lack of reporting put people at further risk of harm. When accidents and incidents were reported, records we looked at showed that accident forms were not consistently analysed to identify and patterns. On occasion a pattern had been identified and action had been taken to refer people to the relevant health professionals. However it was not always clear how staff should minimise the risks of further incidents and keep people safe.

The provider had failed to ensure that there were systems and process, operated effectively, to prevent people from abuse and keep them safe. This is a breach of Regulation 13(1)(2)(3)(6)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough trained staff on duty to meet people's needs and throughout the inspection staff were often rushed. We were told by the acting manager that the Manor House had a minimum of four staff on each shift to support 13 people, many of whom had complex needs. Staff rotas for the Manor House showed that between 28 December 2015 and 03 January 2016 on one day there was only one staff on the early shift, on four days there were two staff and on two days there were three staff. The rota showed that the late shift was covered by one staff on one day, two staff on four days and three staff on two days. The night shift was covered by one staff on two nights and two staff on the remaining five night shifts. Everyone in the Manor House needed support and / or prompting with personal care. A number of people required support with their mobility, and some people needed support with eating and drinking. We observed that people were left for long periods without support. When staff were with people there was little engagement or rapport. Staff watched people from a distance, and stood together talking with each other. Staff in the Manor House told us that even when fully staffed there were not enough of them. We asked what impact this had on people and staff commented, "Huge impact. People don't get to do as many activities. Sometimes care isn't met, sometimes people are left for an hour in wet [incontinence] pads. I believe it should be four carers plus a team leader. People are left for long periods of time, a film is put on and they are left". A member of staff commented, "I always thought there should be three carers and one team leader. Some days we manage on two staff".

Staffing levels were not planned around people's activities and appointments. Staff and people told us that activities and health appointments were frequently cancelled because of insufficient staffing. Records we looked at confirmed this.

Across the service the provider relied heavily on the use of agency staff. There was no system in place to ensure agency staff had the necessary skills or knowledge to support people safely and meet their needs. A number of people had complex health needs which some agency staff were unaware of but were given responsibility for providing support to that person for a number of hours. For example, a regular agency staff had previously worked in the neuro rehabilitation unit. They were working in the Manor House at the time of the inspection and told us no information about people was handed over to them. They said they had asked a member of staff if people had any behaviour they should be aware of and were told 'No, they might shout. No-one is known to be violent'. They had not been made aware of a person who received one to one support to protect people living in the service.

Staff told us they did not feel there were enough staff. People living in the Bungalows required support to learn and maintain independent living skills. Staff told us it was not possible to support people with this due to insufficient staffing levels. Instead of supporting people to shop for food and cook their own meals, staff did this on their behalf to 'save time'. There were two staff supporting the six people living in the Bungalows and at times there was only one member of staff. One member of staff commented, "There is often a gap between 08:00 and 09:45. This is pretty

bad because that is when people need their medicines, prompting for personal care and breakfast. Some people have to wait". Staff in the Bungalows did not have time to develop relationships and get to know people because there were not enough staff. Five of the six people living in the Bungalows needed support to go out so they were not able to leave the Bungalows and spend time in the community when they wanted to. Staff told us they were unable to provide this support consistently and most people could not go out. Records we looked at showed that people had not been out or had support to maintain their skills. For one person living in the Bungalows this lack of support with independent living skills meant they were moving back to the Manor House.

Another member of staff commented, "Staffing is always an issue. It's difficult to get staff. Five people need a member of staff to go out". This had a negative impact on people. For example, one person's records showed that they were unable to attend an important medical appointment on 3 November 2015 because there was 'no driver'. The appointment was subsequently rebooked for 18 November 2015.

In the neuro rehabilitation unit staff said, "There is just enough staff to get by but that's not acceptable". Staff told us that they felt overworked and that the morale had been low over the last six months.

The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not clean and tidy and was not free from offensive odours. An audit completed by staff from the head office on 16 November 2015 had highlighted this noting 'Carpets had multiple spillages and some smelled of urine, urine odour on entering the unit'. Some areas of the service were in need of redecoration and flooring and carpets needed replacing. For example, the downstairs bathroom in the Manor House was in need of repair. Staff told us that this bathroom was due to be refurbished and had not been used for bathing for a long while. The flooring around the toilet was heavily stained. The walls in the bathroom were dirty.

Staff told us, "Cleaning isn't that good. The toilets are stinky and the flooring needs updating" and "It's definitely not clean here. All the bathrooms need a clean and it needs painting". A member of housekeeping staff told us, "Laundry is a bit of a grey area. I've been told soiled clothes go in the red bags but I'm not sure". They told us how they would clean soiled clothes in the red bags and they said they would just rip open the bag in the laundry bin and carry them at arm's length. They said that they had not completed infection control training and that they had never been told to wear a protective apron when dealing with soiled clothing. Staff also lacked awareness of good hygiene practices when handling people's medicines. We observed that staff did not use anti-bacterial gel or wash their hands between each administration of medicine.

There were cleaning schedules in place in the Manor House but one member of staff told us "I don't really fill them in although I know I should". There were no cleaning schedules for the Bungalows. Outside clinical waste bins were stored in an appropriate place; however, these were filled with clinical waste and were unlocked on both days of the inspection. There was a risk that unauthorised personnel could access them easily.

The smoking room in the Manor House was dirty and poorly lit. The armchairs were tatty and badly stained. Although there was ventilation in the room it smelled strongly. Foot operated bins were not consistently lined so that they could be emptied easily and in the downstairs toilet in the Manor House the foot pedal was broken. We raised this with the acting manager who told us that there were plenty of spare ones. On the second day of the inspection this bin was still in place. In the Bungalows there were some handwritten maintenance requests for things such as, toilets not flushing, washing machines not working and pipes leaking. Follow up actions were not consistently recorded. Staff commented, "Maintenance is a sore subject. The maintenance person said that this is the caretaker's job. I'm not sure if the jobs here have been solved, they should be written on the back of the folder when completed" and "I don't know why the maintenance log updates haven't been completed. That's not down to me".

The provider had not ensured that the premises were clean, suitable for the purpose for which they are being used and properly maintained. This is a breach of Regulation 15(1)(a)(b)(c)(d)(e)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not consistently managed safely, handled appropriately, stored safely and securely or disposed of in

line with guidance. The provider had a policy, due to be reviewed in Spring 2016, which covered all aspects of medicines management; however, this was not signed by staff to show that they had read and understood it. Some staff, in the Bungalows, told us that they did not know the system for re-ordering medicines and because of this one person's medicines had run out.

People's medicines were supplied by a pharmacist using a Monitored Dosage System. Medicines were in individually labelled blister packs which eliminated the need for secondary dispensing or 'potting up'. However, in the Bungalows staff moved the medicines from the blister pack into a small plastic pot before supporting people to take their medicines. Current guidance states that secondary dispensing should not be used as there is an increased risk of errors occurring so staff were not following best practice.

In the Bungalows there were three different types medicine administration records (MAR) in use so there was a risk of duplication and confusion due to the use of different codes. When people were able to self-medicate there were no risk assessments or review systems to make sure people managed their medicines safely. People's medicines were not consistently re-ordered when they needed to be. For example, on 26 December a member of staff had noted on a piece of paper that a person living in the Bungalows had run out of paracetamol. Staff told us the acting manager had been emailed and that they had left a note in the handover book for the team leader. This person had missed nine doses of their pain relief and staff told us that they had been using a pain relieving gel. We discussed this with the acting manager on 29 December 2015 and they found that the new prescription had not been collected as staff had previously told them. The acting manager immediately arranged for a member of staff to collect the medicine from the pharmacy.

In the Manor House the MAR were clear and staff told us that they asked a peer staff member to check the MAR for any gaps or omissions at the end of the shift but they were unsure if everybody did this. There was a record of staff who had been assessed as competent to administer medicines. The medicines trolley was kept locked at all times. Staff told us they did not sign the MAR until they had seen the person take their medicine. However, when we looked in the medicines cupboard at the stock to be returned there was a single anticonvulsant tablet (this is a drug that prevents or reduces the frequency of seizures in various types of epilepsy) that had been found on one person's floor on the morning of 29 December 2015. The medicine should have been taken at 20:00. Staff told us that this person preferred to cup their medicines in their hand and 'flip' them into their mouth. It had not been noticed that one had gone astray and all the medicines given at 20:00 had been signed for on the MAR so this person had not received their medicine correctly.

In the neuro rehabilitation unit the MAR were in good order. Medicines were stored safely, however, there were a large amount of unused medicines awaiting disposal. We were told, following the inspection, that this was due to the seasonal holiday.

The provider had not ensured people were provided care and treatment in a safe way and that medicines were managed safely. This is a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment and selection policies were not robust and thorough to make sure that staff were suitable to work with people. Staff completed an application form, gave an employment history, provided contacts for the provider to obtain references and had a formal interview as part of their recruitment. We looked at four staff recruitment files. Three of these files had unexplained gaps in people's employment history. References had been obtained from different people than noted on the job application and there was no explanation why this was. Checks were done with the Disclosure and Barring Service (DBS) before employing any new member of staff to check that they were of good character. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One of the staff files had a tick to note that a check had been completed but there was no reference number or evidence that this had been seen. A disciplinary process was in place and this was being followed by the management team.

The provider had not ensured that recruitment procedures were operated effectively. This is a breach of Regulation 19(1)(a)(b)(2)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People did not receive effective support to meet their needs because staff were not trained or supported to have the right skills, knowledge and qualifications necessary to give people the right support. Staff said that they did not always feel confident or competent and some said they had asked for help with training but this had not happened. The acting manager did not have an oversight of what training had been completed across the service or when training was due to be completed or renewed because there was no training schedule in place to monitor this. We discussed this with the acting manager who told us that they had identified this shortfall and were completing a training schedule to identify staff training needs. The acting manager provided us with an overview of staff training which did not identify staff's individual training needs but confirmed that there were staff training needs outstanding. For example, 27% of staff had completed fire safety training, 65% had completed safeguarding vulnerable adults training and 79% of staff had completed moving and handling theory but there was no record of practical training to ensure staff were confident and competent to support people to move safely.

A member of kitchen staff said that they had not completed any recent health and safety or food hygiene training and the acting manager provided us with a report of completed training which confirmed that no staff had completed training on food hygiene. Staff had not received specialist training to meet some people's specific needs, such as, acquired brain injury, behaviours which may challenge others, catheter care and epilepsy. Therefore we could not be confident that staff had the necessary skills and knowledge required to meet people's needs. Staff told us that they had not completed any training about acquired brain injury and felt that this should be a priority. Many staff felt that they should have training on how to positively manage people's behaviours and use de-escalation techniques to enable them to provide people with safe and effective support. The lack of training put people at risk of receiving inadequate care. Where staff had received training, the provider did not assess staff knowledge after training and could not be assured staff had understood the training and were confident and competent to carry out their roles effectively.

The provider did not have a system in place to monitor staff performance or to ensure staff received support and guidance. Staff told us they were struggling with their responsibilities and found the absence of support – both formal and informal had an impact on them and the care they delivered to people. Staff were not coached and mentored through regular one to one supervision, competency checks or review meetings. Staff said, and records confirmed, that they did not attend regular supervision meetings and some said they had not had an annual appraisal to discuss their performance and talk about their training and development needs for the following 12 months. The acting manager told us, "We are setting structures for appraisals, training and supervisions". Staff told us they were 'frustrated' with the lack of support and staff commented, "We have one to one [supervision] but I don't feel they are confidential so I hold back in them" and "I haven't had supervision for over a year. It is hard work here and you get no praise".

The provider had failed to ensure that staff received appropriate support, training, professional development supervision and appraisal as is necessary for them to carry out the duties they are employed to perform. This is a breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA DoLS require providers to submit applications to a 'Supervisory Body' to do so. The acting manager had knowledge of the MCA and the DoLS and was aware of their responsibilities in relation to these. The need to complete more DoLS applications had been highlighted as a shortfall

in November 2015 during an internal audit and action was being taken to remedy this. Some applications had been made in line with the guidance to the Supervisory Body and further applications were in the process of being submitted by the acting manager.

When people were unable to give valid consent to their care and support, staff did not consistently act in people's best interest and in accordance with the requirements of the MCA. Care plans did not show that people had been supported to be involved with, and agree, the planning of their care and treatment. Only 40% of staff had received training on the MCA. Some people were subject to restrictions including the use of bed rails which prevent people from falling out of bed. There was a risk that people may receive unsafe or inappropriate care because there were no informed consent forms to indicate if the use of bed rails or wheelchair lap straps had been agreed with people or their representatives or to show that these were the least restrictive options available.

Some staff did not understand or have a good working knowledge of the key requirements of the MCA and how it impacted on the people they supported. These principles were not consistently put into practice effectively to ensure that people's human and legal rights were protected. Some people did not have the capacity to make complex decisions. In the neuro rehabilitation unit mental capacity assessments were completed and meetings were held with people, their relatives and health professionals to ensure that specific decisions were made in people's best interest. However, in the Manor House and the Bungalows people's capacity to make specific decisions was not consistently taken into account and capacity assessments were not always completed. A member of staff in the Manor House told us that they had not had any MCA training. They said that they had heard of a best interest meeting but didn't know what it was. They said they thought one person did not have capacity to make certain decisions; however, there were no capacity assessments in the care plan or any record of measures taken to support people to form their own decisions.

The provider did not ensure that care and treatment was provided with consent of the relevant person. This is a breach of Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health needs were not consistently monitored and care and support were not consistently provided to meet any changing needs. Staff did not always know what to do to make sure people had everything they needed. Staff in the neuro rehabilitation unit had a good knowledge about how each person liked to receive their personal care and what they liked to do but some staff in the Manor House and the Bungalows did not know people well. For example, one member of staff (from the Manor House), told us "I know their needs because I read their care plans" and they were able to tell us about the person they were supporting and other people living there. However, another member of staff said that they did not know about the people living in the Manor House and had not read any care plans. Another member of staff (from the Bungalows) said, "I don't know much about [these two people's] past or how their injuries occurred".

People's health needs were not always met or known by staff. This put people at risk of harm. For example, some people had catheters in place (this is a drainage tube for urine and a tube is inserted through the lower abdomen into the bladder). In the Bungalows one person's care plan noted 'can change and empty own bag but sometimes puts straps on wrong'. There was no further guidance for staff on how to support this person in the way that suited them best. In the Manor House there was no guidance for staff on what to do if a catheter tube became blocked or if it came out. Staff said they assisted with the daily care but that there were no specific risk assessments in place. They told us that one person had a long history of repeated urinary tract infections (UTI) and that they were "so much better when encouraged to keep a high fluid intake". This person was currently taking antibiotics for a UTI. We checked to see if there was any guidance for staff about supporting this person to drink fluids regularly. Staff told us that here had recently been "over industrious archiving of hard copy care plans" but they said what volume of fluid they would expect someone to drink in order to avoid infections. We checked the electronic care plan system but this information was not documented. Staff showed us this person's daily fluid intake records and most had been well completed. However, on 27 December 2015, whilst taking antibiotics for a UTI, there was no recorded intake of fluid between 06:30 and 20:45.

There was a risk that people could receive unsafe or inappropriate care due to a lack of guidance for staff. In the Manor House, there was no risk assessment or care plan relating to people's catheter care. Some people needed insulin to help keep their blood sugar levels from being too

Is the service effective?

high or too low. A member of staff supporting people in the Bungalows told us that they were not able to explain what care someone with diabetes needed and did not know the signs a person would display if they were experiencing either hypoglycaemia or hyperglycaemia symptoms. They told us that if the person "looked under the weather" they would give them two glucose sweets. This lack of knowledge and absence of guidance put people at serious risk of harm, and life threatening illness.

The provider did not ensure that people's care and treatment was appropriate, met people's needs or reflected their preferences. This is a breach of Regulation 9(1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff in the neuro rehabilitation unit told us how they cared for each person on a daily basis to ensure they received effective personal care and support. Staff chatted with people in a cheerful manner and allowed time for people to respond. Staff worked effectively together because they communicated well and shared information. Health professionals, such as, occupational therapists and physiotherapists, were involved to make sure people were supported to remain as healthy as possible. If people became unwell staff acted quickly and worked closely with other health professionals to support people's health care needs.

People's opinions on the food varied. People said, "Food is pretty good; sometimes they bring it to me in my room" and "There's no choice, but the majority of the time it's ok. Sometimes I don't eat it and they bring me something else". Staff commented, "The range of food is not always the best. We work with the dietician but the food isn't always the best quality" and "I wouldn't eat it; it's bland".

Kitchen staff knew about people's favourite food and drinks and about any special diets. One person told us "The cook is very good. They know what I like and that I'm fussy and they will cook a separate dinner if I want. There's plenty of it and the meals are good".

In the Bungalows people were given £30 a week to buy their food and were supported by staff to write their shopping list. Some people went shopping with support from staff and staff completed the shopping for others. There was no food and nutrition guidance in people's care plans for staff on how to support people to maintain a balanced diet and sustain good health. Staff told us that some people needed support to choose what to cook and others needed support with the cooking.

The food looked appetising; people ate well and took the time they wanted to eat their meal. Staff took into account people that wanted to eat alone or in their own room. Some people needed to be supported or encouraged to eat their meal. Staff did not sit with people and focus on their dining experience but stood by them which compromised their dignity and independence.

In the neuro rehabilitation unit there was detailed guidance for staff on what people could do for themselves and what support they needed to prepare their breakfast. For example, there was information on how to support people in the way that they had chosen with one person's care plan stating that they had 'expressed a wish to make their own breakfast daily' and directed staff that 'X is able to walk to the toaster and put in the bread' and 'hand over hand guidance required to spread butter and jam on toast'. If staff were concerned about people's appetites or changes in eating habits they sought advice from the relevant health professionals, such as dieticians and speech and language therapists.

The design and layout of the service was suitable for people's needs in some areas of the service, for example, in the neuro rehabilitation unit. However, there was not good wheelchair access in the Manor House. We observed people using wheelchairs struggle and use upper body strength to manoeuvre into the lift and people wishing to smoke needed someone to open the door for them. The premises and grounds were not well maintained and not adapted so that people could move around and be as independent as possible. Some areas of the service had 'grab rails' to assist people moving around the service and other areas had no rails. We observed some people struggling to move around the service safely, holding onto walls where there were no grab rails, or waiting for staff to pass in order they could be assisted. This did not promote people's independence and put people at risk of harm from falls.

We recommend that the provider seek advice and guidance from a reputable source about supporting people with their mobility needs.

Inadequate

Is the service caring?

Our findings

People told us that they were happy living at the service. People said "I'm very well looked after here", "They [staff] are very friendly, and they talk to me as if I'm a person. I've been in a few places and this is the best", "I like it here" and "It's nice. I get the care I need. If I ask for help I get it but they leave me to get on with things if I want".

People were not always treated with kindness or dignity or respect. In the Manor House we observed several occasions over the two days of our visit where staff did not talk or interact with people. Staff stood in doorways and watched people or spoke with each other and ignored people's requests or attempts at communication. At lunchtime in the Manor House we observed staff standing around the outside of the dining room, again watching people but not interacting or having conversations. When we spoke with staff about this they told us "We always stand. We never sit with people". This was institutionalised practice and did not promote people's dignity and respect.

The ground floor bathroom in the Manor House had a ventilation grate in the door which staff looked through to see if there was anyone in there. The grate was open throughout the inspection and we saw the cleaner look through it before they entered. This did not promote people's privacy and dignity.

Records were not consistently written in a dignified and respectful manner. For example, on a cleaning information guide for staff it noted, 'X is lovely but can be moody if they are watching a film they like'. Another care record noted, 'X's personal hygiene and personal appearance is poor and unkempt'.

In the Manor House some people displayed behaviour which may challenge others and, due to their health conditions, were not always able to express their needs. There was no guidance for staff to follow to positively manage people's behaviour. There were no suggested actions for staff to take to reduce people's anxiety or agitation. Staff did not know people well, so there was a risk that they would not able to quickly detect if people were in pain or discomfort, and respond to people's needs appropriately. When people did become distressed or agitated, staff did not have guidance on how best to intervene and use appropriate de-escalation techniques, such as, listening and distraction skills and there was no training on behaviour management. One member of staff said, "I don't think we can give proper care; we don't get proper training in challenging behaviour". It was evident that staff did not have enough skills and experience to manage situations as they arose.

People were not involved or consulted about the care and treatment they received. People's care plans were written by staff and were not shared with people or their representatives. The information contained in these plans was not agreed by the person and / or their representatives, to ensure that they were meaningful and relevant to people's interests, needs and preferences. All care plans were kept on computer. A high number of staff told us they were not confident in using the computer system and that it was "complicated". They said they rarely read people's care plans or any updates on the system. A senior member of the management team told us "This is not the best system for Hothfield but we have to use it as it's the system all services use". There was no capacity for agency staff to use the electronic system unless they were regular agency staff who had completed the necessary training. Agency staff recorded their notes and a staff member transferred them to the electronic database. There was a risk that information about people's individual needs may be missed. On the neuro rehabilitation unit staff told us that this was 'countered by a robust verbal handover' at the beginning of each shift.

In the Bungalows a new member of agency staff said they had to learn 'on the job' during the day about how best to communicate with people. They told us that they had not seen any care plans. We looked at the electronic care plan and there was no guidance for staff in people's care plans about communication. Staff had not built strong relationships with people and their families and were not familiar with their life histories, wishes and preferences.

People living in the Bungalows had no documented life history in their care plans so staff were not able to talk with people about their past. There were no plans in place for people to develop their independent living skills with a view to moving into the community because people did not have meaningful and achievable goals in place. Staff told us that some people would be able to live on their own but were not able to tell us how people were being supported to achieve this.

People in the neuro rehabilitation unit had a more detailed life history in a client folder on the nurse's station. There

Is the service caring?

was guidance for staff of how best to support people in the way they preferred which had been written by health professionals including occupational therapists and speech and language therapists.

People living in the Manor House had a 'life folder' which was being updated. These contained basic information in large print and were aimed at orientating people with memory loss and difficulties with cognition. There were photographs and information about people's brain injury and a brief section which outlined things such as, what time people liked to get up, their preferred activities and their preferences for washing and dressing.

Some people were not able to communicate verbally due to their health conditions and those that could not express their needs did not always receive the right level of support, such as, in managing their activities or their behaviour. For example, a number of staff told us that a person living in the Manor House did not like to be supported with their personal care and that their room smelled unpleasant. We discussed this with the acting manager who told us that the service's psychologist had spoken with the person but had not managed to build up a rapport with them. We asked the acting manager if they had considered using an external psychologist and they told us that no-one had considered involving any external psychologist for guidance and advice but that the Community Mental Health Team were involved in supporting this person. The acting manager also told us that this person had regular meetings with their key worker. This person's care plan noted, 'Staff and keyworker to have regular interactions with X' and 'Staff and keyworker to work on finding out X's interests'. When we checked the care plan there was no record of any keyworker meetings. Therefore staff were not doing everything practicable to make sure that people's needs were being met and reflected their preferences.

The provider did not ensure that people were involved in or receiving care and treatment was appropriate, met people's needs or reflected their preferences. This is a breach of Regulation 9(1)(a)(b)(c)(2)(3)(a)(b)(c)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff in the neuro rehabilitation unit displayed caring and considerate attitudes towards people and consistently took care to ask permission before intervening or assisting people. Staff communicated with people in a way they could understand and were patient, giving people time to respond. Staff had knowledge of people's individual needs. Staff made eye contact with people when they were speaking to them, spoke slowly and clearly and checked that people understood. At one point during the inspection staff were visibly overjoyed. Staff told us that one person had been able to shave himself for the first time since he had been living in the unit. Staff commented "This is so significant. Even the smallest thing is a huge achievement" and "It might take him a little while but this is amazing".

Inadequate

Is the service responsive?

Our findings

People did not receive consistent, personalised care, treatment and support in the way that they needed or had chosen. There was no clear care and support planning system which people and their loved ones were involved in. The service did not have a strong, visible individualised care culture and staff did not know people and their relatives well. Staff had not developed positive relationships with people because they did not have the time to do so. During the inspection staff were not responsive to people's individual needs, did not promote their independence and protect their dignity. There was no guidance in the care plans about people's daily lives and indicators of what to look for should people be unhappy, to make sure they were being positively supported.

Staff working in the Manor House and the Bungalows were not consistently given the information they needed and handovers were not detailed. For example, a regular agency staff had previously worked in the neuro rehabilitation unit. They were working in the Manor House at the time of the inspection and told us no information about people was handed over to them. They said they had asked a member of staff if people had any behaviour they should be aware of and were told 'No, they might shout. No-one is known to be violent'. They had not been made aware of a person who received one to one support to protect people living in the service. One member of staff commented on the communication as "Has its downfalls, sometimes it's like Chinese whispers".

People's support needs were not always known by staff. A person who had recently moved to the service had not had an assessment of their needs prior to moving in. This assessment would be used so that the provider could check whether the service could meet people's needs or not. It would also be used to develop a care plan based around the person's support needs in all areas of their care. We were told the person had moved because of an emergency. However, the acting manager was unable to tell us what the 'emergency' was, or why the person had not been assessed prior to admission. This person had challenging needs, and a care plan to support them with this had not been developed. Staff we spoke with were unfamiliar with the person's needs. When asked when a full assessment of needs would be undertaken we were told, "There is no point as he might move again".

People did not participate in or contribute to the planning, assessing and reviewing of their care. Each person had a care plan which had been written by staff and did not show how people had been involved in the assessment, planning and reviewing of their care to make sure that their health needs would be met in a way that they preferred. Care plans were not person centred and did not give clear guidance for staff on people's everyday support needs and how these should be met in a way that suited them best. These varied in detail and description, some were written in a negative way and when goals or aims had been identified there was no guide to how these would be achieved. For example, one person's 'activity care plan' identified needs as; 'Can be aggressive towards other clients and staff', 'Personal hygiene and personal appearance is very poor and unkempt. This can cause difficulty when out in the community, as their appearance can be socially unacceptable'. This person's aims and goals were noted as; 'To have more social interactions', 'Behaviour to be managed during activities' and 'Appearance to be acceptable during activities'. Guidance for staff on how this should be achieved included; 'Ask who they would like to participate in activities with' and 'All staff to also offer one to one activities'. An evaluation form with the care plan was blank and there was no information on what staff had tried, what had worked and what hadn't. There was no evidence that this person had been consulted or involved in the planning of their care.

On the whole care plans did not contain information that was important to the person, such as their life history, likes and dislikes, what they could do independently and current and past interests. Plans included brief details about people's personal care needs, physical health and mobility needs. The care plans were more detailed in the neuro rehabilitation unit and had a clear rationale based on an assessed need or diagnosis but were not person centred. It was difficult to get a sense of the person's life, culture, interests and hobbies prior to the acquired brain injury.

When people's needs changed the care plans and risk assessments were not consistently reviewed and updated to reflect this to make sure that staff had up to date guidance on how to provide the right support, treatment and care. For example, one person needed to have their fluid intake monitored and had a history of repeated urinary tract infections (UTI). This person was being treated

with antibiotics for a UTI and reviews should have been completed regularly, to make sure the person was having sufficient fluids, and one review should have been completed on 19 December 2015 and had not been done.

A keyworker system had recently been put in place by the acting manager. A keyworker is a member of staff who is allocated to take the lead in co-ordinating someone's care. In the Manor House people had the name of their keyworker and a photo of them in their room. Meetings between the key worker and the people they supported were not held regularly to make sure people's needs were being met in the way that suited them best.

The provider did not ensure that care and treatment was appropriate, met people's needs or reflected people's preferences. This is a breach of Regulation 9(1)(a)(b)(c)(2)(3)(a)(b)(c)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Across the whole service people were not supported and encouraged to keep occupied and there was not a range of meaningful activities available, on a one to one or a group basis, to reduce the risk of social isolation. One person commented, "I want to go home. I don't know why I'm still here. No one tells me why I'm still here. I feel fine and well, I just want to go. I haven't been out for ages. I can't remember the last time I went out. I haven't had a meeting about my plans for the future or when I will be moving on; I haven't been informed. It's alright here but it is boring" and another person said "I can't remember going out. Sometimes I go out in the garden but I can't remember when".

The provider employed an activities co-ordinator but we were told that due to a shortage of drivers, they spent much of their time taking people to appointments. The acting manager and some staff told us that people were supported to go out and that there were regular activities, such as bowling, day trips and swimming. Records did not show that people were offered regular activities but staff continued to tell us "I know there have been activities" and "They wouldn't remember this anyway".

Staff told us that there were not always enough staff to support people to go out when they wanted. Staff said, "Activities need a lot of improvement. There are things like bingo and quizzes. External activities quite often get cancelled due to a lack of drivers"; "They do nothing. People are bored. The quiet people get forgotten. The people with challenging behaviours get all the attention" and, "It's hard to engage with people. Some activities are not age appropriate and a lot more could be done".

In the Bungalows one person's care plan noted 'Has a short attention. Can often walk off. Needs encouragement. Help them with regular activities'. We looked at the diary to see when this person was supported to go out and found that they had gone out eight times in the previous 44 days. This person told us that they last went out on 4 November 2015 which was reflected in the diary.

In the Manor House records showed that one person was last supported to go out in August 2015 to a car boot sale. We discussed this with the acting manager who told us that this person needed two staff to support them in the community and that they had regular activities. We requested to see records to show what activities this person had been involved in for November and December 2015. We were given the following information: 8 December 2015 had her nails painted and hands moisturised this afternoon; 7 December 2015 has walked around the building this morning. Has watched TV this afternoon. Sat and watched staff and other clients trying to make a caravan made out of matchsticks; 29 November 2015 watched a film this afternoon in the lounge. This person's care plan noted that the things they liked included playing catch, rides out in the car, swimming and walks round the ground to see the rabbits and dogs. Other people's activities were frequently noted by staff as 'watching television', 'sleeping' and 'walking up and down the corridor'.

The provider did not support people's autonomy, independence and involvement in the community. This is a breach of Regulation 10(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy in place which gave guidance on how to handle complaints. People told us that they knew who they would raise any concerns with and that they felt comfortable in doing so. One person said "I can't say I have any real complaints. If I had I'd tell the staff". A complaints policy was displayed on the wall in the Bungalows. This had very out of date information about who to complain to and where to send a complaint. For example, the address for the Care Quality Commission showed an address that had not been used by the Commission for over five years.

Inadequate

Is the service responsive?

Surveys to request feedback on the quality of service received were sent twice a year by the head office. There was no routine request for feedback from people living at or leaving the service but staff told us that an I-Pad was used with people and relatives on an ad hoc basis. There was no analysis of feedback available to show if any concerns, complaints or compliments were used as a learning opportunity or to drive improvement.

The provider did not operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. This is a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were records in care plans of visits from, and to, doctors, district nurses, dentists, chiropodists and other professionals. Referrals to health professionals, such as occupational therapists, dieticians and physiotherapists, were made when needed. Weekly multi-disciplinary meetings were held which involved health professionals, including psychiatrist, speech and language therapist, psychologist and physiotherapist. A GP visited the neuro rehabilitation unit each week to review people's physical health. Action points were noted in the minutes of the meetings.

There was clear guidance, which included photographs, for staff in the neurorehabilitation unit regarding supporting people with their mobility or how people should be positioned. Staff told us how they positioned this person and records confirmed that this was done. There was further guidance on how to move people safely which included which specialist equipment, such as hoists and slings, should be used to ensure staff knew how to move people safely.

Inadequate

Is the service well-led?

Our findings

The service was not well led and lacked leadership. This had a detrimental impact on the service people received. People did not get their needs met, and people were at risk of harm from others as staff did not have the skills to keep people safe.

Staff were concerned about the quality of the service being delivered. Staff told us they did not feel supported or valued by the management and were not clear about what was expected of them. Staff said they did not understand their roles and responsibilities and were not clear of their individual responsibilities on each shift. One member of staff told us that they used to have an allocation sheet at the beginning of the shift so that they knew what they needed to do and who they were supporting but said that staff didn't follow it. This was confirmed as an issue in the minutes of a staff meeting held on 5th February 2015.

Staff did not feel that there was an open and transparent culture. Staff said that they did not feel supported and enabled to question practice or raise issues about the quality of service delivered. Staff told us that when suggestions had been made they did not feel they had been listened to and that they were 'banging their head against the wall'.

Staff told us, "Morale is quite low. The staffing levels have a huge impact on staff. I think there is a lot of pressure on the acting manager. We do have a good team here but we don't feel appreciated. I always thank staff but we don't get much [thanks] from the management", "I feel valued by the occupational therapist and sometimes by the acting manager. Sometimes [management] doesn't listen. They could improve their reassurance and the way they talk" and "I like it here most of the time. Some days other staff might not pull their weight. Team leaders have a lot to deal with. The floor could be managed better".

The acting manager said, "Teams either come together or fall apart and everyone is pulling together. We've made huge improvements in the last two months". We asked staff for their views on the management and leadership of the service. Some staff said that the acting manager "Has an open door policy", "Management is getting better. I don't feel supported. Nothing changes. I don't feel valued" and "We get told face to face by [the acting manager] when things change and the team leaders tell the support workers. It's better now that we can say what we think".

There was no clear auditing system in place to monitor the quality of the service being delivered. Audits had been completed sporadically in July and August 2015 but there were no records of what action needed to be taken, by whom and when it should be completed by. We were told that these had been done by the previous registered manager and that staff had not seen any action plans. In the Bungalows staff checked the temperature of the clinical room but this was not completed consistently. For example, from 01 to 28 December 2015 there were four days checks missing. Staff said they were not sure who was responsible for auditing the medicines.

An action plan had been put in place, by the registered manager, in April 2015 which included; 'Improve information sharing, Staff morale and interaction, Activities / resources for activities'. Shortfalls in the quality of service delivered had been identified during a head office audit in November 2015 and the hospital director told us that there were clear plans in place to address these. We asked the acting manager to see an up to date action plan. They told us, "It's not written down, it's in my head and on scraps of paper". It was evident during our inspection that the shortfalls identified in April and November 2015 had not been effectively managed or resolved.

The provider did not have the required oversight and scrutiny to support the service. Staff told us they were not confident that the provider knew what was happening at the service. The provider had not taken action to monitor and challenge staff practice to make sure people received a good standard of care. For example, there were no documented observations of staff or competency assessments. The provider did not ensure that the care provided was safe, that staff were trained effectively or that care was person centred.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and staff knew where to access the information they needed. Staff we spoke with were aware of the whistle blowing policy and how to blow the whistle on poor practice to agencies outside the organisation. However, staff said they were not confident that the management would listen and act on what they said.

Inadequate

Is the service well-led?

The provider did not have systems and processes in operation to assess, monitor and improve the quality and safety of the service. Feedback on the service provided from relevant persons had not been obtained by the provider so they could use it to continually evaluate and improve the service. This was a breach of Regulation 17(2)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not in good order or always kept up to date. When we asked for any information it was not immediately available. For example, the provider did not have an overview of individual staff training needs and did not have any analysis of accidents and incidents to identify patterns and trends. Records were stored securely to protect people's confidentiality.

Accurate and complete records in respect of each person's care had not been maintained. Records of the care and support people received or offered were limited. People were at risk because decisions about their care were made based on inaccurate or incomplete information. For example, not all accidents and incidents were recorded.

The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of each service user, including decisions taken in relation to their care. This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC uses this information to check that appropriate action had been taken including action to keep people safe. Notifications of incidents that affected people's health, safety and welfare had not consistently been submitted to CQC in an appropriate and timely manner in line with CQC guidelines so we were not aware of the number or significance of events which had occurred at the service.

The provider had not notified the Care Quality Commission of significant events that occurred at the service. This was a breach of Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009.