Medstar Domiciliary Care Services Limited

185 Herbert Road

Inspection report

185 Herbert Road
London
SE18 3QE

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19 September 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 September 2018 and was unannounced.

185 Herbert Road is a care home, provides accommodation for people who require nursing or personal care for up to three adults who have a range of needs including learning disabilities. At the time of the inspection the home was providing care and support to three people.

185 Herbert Road is managed by the provider, Medstar Domiciliary Care Services Limited, since its registration in September 2017. This is their first inspection.

The service did not have 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. The current manager told us that the previous registered manager left the service in April 2018, and that they joined the service as a manager, two months before our inspection. The head of operations said that the current manager, is in the process of making an application to CQC to become a registered manager. However, their application was not received at CQC.

We found four breaches of the fundamental standards and regulations. The care service has been fully developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. The premises were not safe. The fire alarm and the fire doors did not confirm to the fire safety standards, sofa in the communal area was not fire rated and the emergency lighting was insufficient. The service was not free from offensive odours. The provider did not manage accidents and incidents effectively to reduce the possibility of reoccurrence. Medicines were not managed safely. The decoration and other adaptations to the premises did not help to meet people's needs. The provider's quality assurance system and process to assess and monitor the quality of the care people received were not effective. The provider had not notified CQC where Deprivation of Liberty Safeguards (DoLS) had been authorised for people as required, so that where needed, CQC can take follow-up action.

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

The service had clear procedures to support staff to recognise and respond to abuse. The manager and staff completed safeguarding training. Staff completed risk assessments for every person who used the service and they were up to date with detailed guidance for staff to reduce risks.

The provider carried out comprehensive background checks of staff before they started working and there were enough staff to support to people. The service had arrangements to deal with emergencies.

The provider trained staff to support people and meet their needs. The provider supported staff through regular supervision and appraisal.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff understood their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff assessed people's nutritional needs and supported them to maintain a balanced diet. Staff supported people to access the healthcare services they required, and monitored their healthcare appointments. The manager and staff liaised with external health and social care professionals to meet people's needs.

Staff involved health and social care professionals and relatives where appropriate in the assessment. However, Health and social care professionals Staff considered people's choices, health and social care needs, and their general wellbeing. However, there was no evidence to suggest that people with profound needs were involved in their care planning and review process and this required improvement.

Staff supported people in a way which was kind, caring, and respectful. However, comments from staff that were not respectful and this required improvement. Staff protected people's privacy and dignity.

People were supported to maintain relationships with people that mattered to them. People's needs were reviewed and monitored on a regular basis. The provider had a policy and procedure about managing complaints and to provide end-of-life support to people. Staff felt supported by the manager. The service worked effectively with health and social care professionals, and commissioners.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The premises were not safe. The provider had not ensured medicines were always being managed safely at the home.

The provider did not manage accidents and incidents effectively to reduce the possibility of reoccurrence.

The service had a policy and procedure for safeguarding adults from abuse, which the manger and staff understood.

The service had enough staff to support people and carried out satisfactory background checks on them before they started work.

Staff completed risk assessments for every person who used the service and provided guidance to reduce risks to people. The service had arrangements to deal with emergencies.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The decoration and other adaptations to the premises did not help to meet people's needs.

Staff asked for people's consent, where they had the capacity to consent to their care.

The provider supported staff through induction, training, supervision and appraisal, in line with their policy.

Staff assessed people's nutritional needs and supported them to have a balanced diet.

Staff supported people to access the healthcare services they needed. The manager and staff liaised with external health and social care professionals to meet people's needs.

Is the service caring?

Requires Improvement

One aspect of the service was not caring.

Comments from staff about people that were not respectful. There was no evidence to suggest that people with profound needs were involved in their care planning and review process and this required improvement.

People and their relatives where appropriate were involved in making decisions about their care and support.

Staff respected people's choices, preferences, privacy, dignity, and showed an understanding of equality and diversity.

Is the service responsive?

Requires Improvement

One aspect of the service was not responsive.

There was not enough stimulation and support to people to follow their interests, and take part in activities.

Staff assessed people's needs and completed care plans for every person.

People knew how to complain and would do so if necessary. The service had a clear policy and procedure for managing complaints.

The provider had a policy and procedure to provide end-of-life support to people.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The systems and processes in place to assess and monitor the quality of care people received were not effective.

The provider had not notified CQC where Deprivation of Liberty Safeguards (DoLS) had been authorised for people as required.

The manager held regular staff meetings, where staff shared learning and good practice so they understood what was expected of them at all levels.

The service worked in partnership with health and social care professionals and commissioners.

185 Herbert Road

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 18 and 19 September 2018 and was unannounced. One inspector and an inspection manager inspected on the 18 September 2018. The inspector returned to the service on 19 September April 2018 to complete the inspection.

Before the inspection we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the commissioners and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During our inspection we spent time observing the support being provided to people. We spoke with two members of staff, the service manager, the area manager, and the head of operation. We looked at two people's care records and four staff records. We also looked at records related to the management of the service such as the administration of medicines, accidents and incidents reports, Deprivation of Liberty Safeguards (DoLS) authorisations, health and safety records, and the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

The premises were not safe. We found that the monthly health and safety audits for June, July and August 2018 had identified concerns regarding faulty fire doors in the communal area of the service but no action was taken until we brought this to the attention of the manager. The manager told us that they had informed their senior management and were waiting for them to action this. We asked the manager to report the fire safety concerns to the London Fire Brigade (LFB) and seek their advice. On the second day of our inspection the LFB carried out their own inspection of the premises and told us the premises fire alarm and the fire doors did not conform to fire safety standards, the sofa in the communal area was not fire rated and the emergency lighting throughout the service was insufficient. We asked a member of staff how they felt about the fire doors not working, they told us, "No it is not safe." The provider told us that they were waiting for the LFB inspection report. In the meantime, based on the verbal feedback from the LFB, the provider confirmed that they had repaired the two fire doors and had bought emergency touch lights. We will follow this up at our next inspection.

On the first day of our inspection we found that the provider had not completed portable appliance testing (PAT) to ensure electrical equipment at the service was safe. As a result of our feedback an external agency completed PAT on 19 September 2018 and found equipment at the service satisfactory.

Staff were aware of the provider's infection control procedures. Whilst people's bedrooms and communal areas were clean and tidy, we found one person's bedroom had offensive odours. Staff told us that the bedroom had been cleaned but some offensive odour remained and that they kept the doors and windows open to try to keep the room fresh. This had not been effective.

The provider did not manage accidents and incidents effectively to reduce the possibility of reoccurrence. For example, on 8 July 2018 a staff member had recorded they had 'Tried restraining [a person.] They hit their head on the side of the door.' We discussed this with the manager who told us the service had a 'no restraint policy' and they had spoken with the member of staff and found that the language they had used was inaccurate. They further told us that they met with the staff member and explained the use of correct language in the incident records and this was discussed in a team meeting. However, the provider and the manager were not able to provide any records of the action. We asked if the person had received medical assistance after hitting their head and we were told they had seen a GP within 24 hours. However, the manager and the provider were not able to provide any evidence that this was the case. Another incident happened on 01 June 2018, when a person had tried to climb out of the bathroom window and 'urgent action' had been identified as being needed to prevent this from happening again. On the first day of the inspection we could open this window wide and, there were no restrictors fitted to it. The provider took action and a window restrictor was fitted the following day on 19 September 2018.

Staff told us that some people could display behaviour that was challenging. The manager told us they had sought advice regarding this from the community learning disability team. We asked to review incident forms relating to the person's behaviour, and were told this was recorded in people's daily notes. The provider confirmed that they do not record individual instances of the person's behaviour as incidents. No

analysis was completed of when the person displayed behaviour that challenged and the manager confirmed there was, "No systematic way of reviewing them [individual instances of behaviour.]" This limited the manager's ability to look for trends and patterns and ways of reducing this behaviour going forward.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed safely. There was a box in the manager's office that we were told contained empty blister packs of medicines. This was moved into the lounge at the beginning of the inspection. When we looked in the box we found a range of medicines belonging to the three people at the service including medicines to help control people's epilepsy and medicines to help people to sleep or remain calm. We asked where these medicines came from and we were told they needed to be 'returned.' Some of the medicines were for use as and when required and others were for everyday use. We asked why there was medicines left over and no one could explain to us why they were being returned. People's medicines administration records (MARs) had been signed consistently for the previous month indicating there were no missed doses but the provider's audit system was not effective, nor were the systems and processes regarding the checking in of medicines so we could not tell if there had been an excess of medicines when they were delivered or if the MAR had been signed and these medicines had not been given as required.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had PRN (as required) medicine protocols in place for any medicines that people had been prescribed but did not need to be administered routinely. PRN protocols gave an explanation of when medicines should be given, the signs to look out for in the person, which meant they would need the medicine, the required dosage and how often the dose should be repeated.

We found some good practice to manage accidents and incidents to reduce the possibility of reoccurrence. Staff completed accidents and incidents records, which included action staff took to respond and minimise future risks, and who they notified, such as a relative or a healthcare professional. Records we looked at showed examples of changes made after incidents occurred. For example, following an incident when a person went out of the premises unnoticed, the front door locks have been changed to reduce reoccurrence. In another incident when a person presented behaviour that was challenging, the community mental health team support was sought. Records showed that actions to reduce future risks were also discussed in staff meetings.

The service had a policy and procedure for safeguarding adults from abuse. The manager and all staff understood what abuse was, the types of abuse, and the signs to look out for. Staff knew what to do if they suspected abuse. This included reporting their concerns to the manager, the local authority safeguarding team, and the Care Quality Commission (CQC) where necessary. The manager told us that there had been one safeguarding concern since the service's registration in September 2017. The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The manager implemented performance improvement plans to make sure they used incidents as an opportunity for learning. The service worked in cooperation with the local authority, in relation to safeguarding investigations and they notified the CQC of these as they were required to do. Staff we spoke with told us, and records confirmed that they had completed safeguarding training. Staff told us there was a whistle-blowing procedure available and they said they would use it if they needed to. For example, one staff told us, "There is a hierarchy of authority. I could whistle blow to the council or social services."

The provider completed risk assessments for every person who used the service. The risk assessments were up to date with detailed guidance for staff to reduce risks. These included, management of medicine, eating and drinking, mobility, and community access. Staff told us how they had followed the risk management plan guidelines so that people were safe. For example, where people had been identified as being at risk from choking staff sought advice from the Speech and Language Therapy (SALT) where a person had been identified as having swallowing difficulties. A risk management plan had been put in place which identified the type of food and the level of support people needed to reduce the level of risk. We observed during the lunch time that people were getting the correct type of diet suitable to reduce risk to them. Records further confirmed that staff followed the prescribed guidance.

Some people could display behaviour that could challenge staff and other people. There was a detailed positive behaviour support plan in place which explained how staff should respond when people became distressed and what may trigger their behaviours..

The provider had arrangements to deal with emergencies. People had personal emergency evacuation plans (PEEPs) in place which gave guidance for staff and the emergency services on the support they would require evacuating from the service. Staff received first aid and fire awareness training so that they could support people safely in an emergency.

The service had enough staff to support people. The manager told us they organised staffing levels according to the needs of the people who used the service. If they needed extra support to help people to access community or healthcare appointments, they arranged additional staff cover. During the inspection someone was in hospital and, the service provided additional staff cover. The staff rota we looked at showed that staffing levels were consistently maintained. Staff told us there were enough staff to meet people's needs. We saw staff responding to people's needs at the service in a timely manner. The service had a 24 hour on call system to make sure staff had support outside the manager's working hours.

The provider carried out satisfactory background checks of staff before they started working. The checks included qualification and experience, employment history and any gaps in employment, references, criminal records checks, and proof of identification. This meant staff were checked to reduce the risk of unsuitable staff working with people. However, one member of staff's criminal records check was not carried out by their current employer, but by their previous employer. As a result of our feedback, the provider told us that they had now made an application for this staff member.

Requires Improvement

Is the service effective?

Our findings

We saw staff's interaction with people and found that they were knowledgeable about their roles. For example, staff knew how to communicate with people and understood their needs.

The decoration and other adaptations to the premises did not help to meet people's needs. We found that the daily health and safety checks carried out for the period from 20 August 2018 to 16 September 2018 had recorded that all floor coverings were secure and without damage. However, we found in one of the bedroom the floor was peeling up, a broken window restrictor with pieces of plastic sticking out of them and smells of urine. In another person's attached bathroom, staff told us that a blocked drainage was cleared few months ago, but the problem was not fully resolved and the drainage continued overflowing. A large black sofa at the back of the lounge was ripped and held together by black stick tape and this did not confirm to fire safety standards. Some people required assistance with their communication and the environment did not support this. For example, there were no visual prompts such as no staff pictures displayed for people to know who would be working with them.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides 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 provider 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 manager was aware of the requirements regarding DoLS and worked with the local authority to ensure the appropriate assessments were undertaken. Where applications under DoLS had been authorised, we found that the provider was complying with the conditions applied on the authorisations. For example, a relevant person's representative, an independent mental capacity advocate (IMCA) was appointed to support a person and they visited regularly. However, the provider had failed to notify us of DoLS authorisations as required.

Staff asked for people's consent to their care. Records were clear on people's choices and preferences about their care provision. Staff we spoke with understood the importance of gaining people's consent before they supported them. We saw staff took non-verbal [facial expression and gestures] consent from people who used the service prior to care delivery.

Records showed that people's mental capacity had been assessed relating to specific decisions about the support they received where staff suspected they may not have capacity to make the decision for themselves. Assessments had been completed in accordance with the requirements of the MCA. Where people had been assessed as lacking capacity we saw that the relevant decisions had been made in their best interests, with the involvement of staff and healthcare professionals, where appropriate. For example, treatment about people's specific healthcare needs such as eye care.

The service trained staff to support people. Records showed induction training was completed in line with the Care Certificate which is a nationally recognised way of training staff new to social care work. Staff also received training in areas that the provider considered essential. This training covered basic food safety, therapeutic management of violence and aggression, epilepsy, autism, medicines management, safeguarding, health and safety, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff training records we looked at confirmed this. Staff told us the training programmes enabled them to deliver care and support people needed. The service provided refresher training to staff. Records showed staff updated their training as and when they needed.

The service supported staff through regular supervision and yearly appraisal. Staff records we saw confirmed this. These records referred to staff wellbeing, staff roles and responsibilities, performance and their training and development plans. Staff told us they worked as a team and could approach the manager at any time for support.

Staff carried out assessment of needs for each person to ensure they could be met, which involved feedback from health and social care professionals. The assessment considered the level of support they required, their choices and preferences, and any identified areas in which they needed support. The assessments covered medical conditions, physical and mental health, personal care, likes and dislikes, mobility, nutrition, skin care needs, and communication needs for example, repeat what a person says back to them. This information was used as the basis for developing personalised care plans to meet their individual needs with goals for example, to maintain overall health and body mass index, and reassure people to walk short distances.

Staff supported people to eat and drink enough to meet their needs. Staff recorded people's dietary needs in their care plan to ensure people received the right type of diet in line with their preferences and needs. For example, we saw guidance in place from the Speech and Language Therapy (SALT) where people had been identified as being at risk of choking. We observed staff following this guidance and providing appropriate support to people during a lunchtime meal in order to manage risk.

There were visual menus available at the home for staff to use as appropriate. We carried out observations at lunch time. We saw positive staff interactions with people. The dining atmosphere was relaxed and not rushed. There were enough staff to assist people. Staff were observed making meaningful communication with people, and encouraged them to finish their meal.

Staff worked with other services to ensure effective joint-working. Staff supported people to access healthcare services they required. We saw contact details of external healthcare professionals, the community mental health team, psychiatrist and GP in every person's care record. Staff completed health action plans for every person who used the service and monitored their healthcare appointments. Staff completed hospital passports for every person which outlined their health needs for healthcare professionals to know when they attended the hospital. Staff attended healthcare appointments with people to support them where needed. This enabled people to receive well-coordinated care and support when they go to use other services.

Requires Improvement

Is the service caring?

Our findings

Comments from staff about people were not always respectful and this required improvement. For example, they told us, "[A person] destroys everything" "[A person] is not allowed to go into the kitchen due to [a person] challenging behaviour" "[A person] does not have the ability to choose. Even if you show him [a person] does not have capacity."

Staff involved health and social care professionals and relatives where appropriate in the assessment, planning and review of their care. Staff completed care plans for every person who used the service, which described the person's likes, dislikes, life stories, career history, their interests and family. Staff told us this background knowledge of the person was useful to them when interacting with people who used the service. However, there was no evidence to suggest that people with profound needs were involved in their care planning and review process and this required improvement.

People were treated with respect and kindness. We observed people appeared comfortable with staff and approached them when they needed something. We saw staff had good communication skills and were kind, caring and compassionate. They used enabling and positive language when talking with or supporting people. For example, facial expression and gestures (nonverbal communication) and British sign language. We saw in a communal area a member of staff coming down to the eye level of a person. During meals staff took time to sit and engage with people in a kind and friendly way.

Staff took an interest in people's personal histories. They were sensitive to their cultural and spiritual needs. They understood how to meet people's needs and preferences in a caring manner. Staff told us, "We do not give [person] non- halal food, they cannot eat pork."

Staff respected people's choices regarding where they preferred to spend time, such as in their own rooms or in the communal area. Staff further confirmed with us that they had enough time to meet people's needs in a caring manner.

Staff encouraged people to maintain their independence. Staff prompted and supervised people where necessary to maintain their personal hygiene, participate in washing and laundry, and for people to assist in the kitchen where they could.

People were treated with dignity, and their privacy was respected. Staff told us, "You give them [people] their privacy." We saw staff knocked on people's bedrooms before entering people's rooms and they kept people's information confidential. People were well presented and we saw examples of staff helping them to adjust clothing to maintain their dignity. Records showed staff received training in maintaining people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

Each person had an activity planner, which included meeting family, and accessing the community. Staff maintained a daily activity record for each person to demonstrate what activity they participated in. However, we saw there was not enough stimulation and support to people to follow their interests, and take part in activities. For example, we saw during the inspection people sat in the lounge in front of the TV without much stimulation, and this wasn't what was on the planner. Some people had profound learning disabilities and there was a lack of specialist provision regarding activities to support their sensory needs, People's activity planners were not reviewed to allow people to be active members of their community and if they would like to change their mind about their interests and choice of activity and this required improvement.

We recommend the provider seeks advice from a reputable source regarding activities for people with learning disabilities.

Staff had developed care plans for people based upon their assessed needs. These contained information about their personal life and social history, their physical and mental health needs, allergies, family and friends, preferred activities, goals, and contact details of health and social care professionals. They also included the level of support people needed and what they could manage to do by themselves. The care plans were in a pictorial format with clear guidance for staff. For example, about dysphagia risk feeding for people who required it, staff monitored their food and fluid intake. Staff also carried out checks every two hours and monitored what people had been doing the day and night. Care plans were reviewed on a regular basis and reflective of people's current needs.

Staff discussed any changes to people's needs with the manager, to ensure any changing needs were identified and met. The manager updated care plans when people's needs had changed and included clear guidance for staff to ensure continuity of care. For example, they included how staff supported people when their diet had changed. Care plans we saw were up to date.

Staff completed daily care records to show what support and care they provided to each person and these showed staff provided support to people in line with their care plans. People received support with their healthcare appointments and nutrition and hydration. The service used a communication log to record key events such as health and safety and healthcare appointments for people.

The provider identified and met the communication needs of people. For example, people's care plans were in a pictorial format and included details about their communication needs, disability, preferred faith and culture, and guidance for staff to provide care and support that met people's need. The manager and staff told us that the service was non-discriminatory and that staff would always seek to support people with any needs they had with regards to their disability, race, religion, sexual orientation or gender.

The provider had a policy and procedure to provide end-of-life support to people. People did not require to receive end-of-life support.

The service had a clear policy and procedure about managing complaints. Information was available for people about how they could complain if they were unhappy or had any concerns. The manager told us that they had not received any complaint since their registration in September 2017. Records we saw confirmed this.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems and processes to assess and monitor the quality of the care people received were not effective. For example, on the first day of our inspection we found that the provider had not completed portable appliance testing (PAT) to ensure electrical equipment at the service was safe. The provider's infection control procedures were not effective. The provider did not manage accidents and incidents effectively to reduce the possibility of reoccurrence. Medicines were not managed safely. The decoration and other adaptations to the premises did not help to meet people's needs. The activity planner was not reviewed to allow people to be active members of their community and if they would like to change their mind about their interests and choice of activity. The provider had not notified CQC as required. The fire alarm system did not conform to fire safety standards, fire doors were not safe or fit for purpose, the sofa in the communal area was not fire rated, and emergency lighting was insufficient. The provider had not picked this up before our inspection. One member of staff told us, "The duty of care seems to be lapsing." Records were not always accurate. For example, the daily health and safety checks carried out for the period from 20 August 2018 to 16 September 2018 had recorded that all floor coverings were secure and without damage. However, we found this was not the case. We noted there was no information about who carried out these checks.

Staff had carried out food, hot water, fridge and freezer temperature checks and they were not accurate. We noted for the period from 1 September 2018 to 19 September 2018 that on all days the temperatures were recorded same. For example, hot water temperature was recorded 40 degrees and fridge 5 degrees Celsius. However, we tested the hot water temperature and found 34.5 Celsius and fridge 10 degrees Celsius. We brought this to the attention of the manager, who said they would monitor this on a weekly basis and during handover meetings daily.

The records management system was not effective. We found on first day of the inspection that some care records and staff records were not available on the premises. The manager told us that they were in their head office and asked us to come again the next day to access them. On the second day of the inspection, staff recruitment and training records, health and safety checks, were made available. However, staff supervision and appraisal, DBS checks, two staff right to work, portable appliances and gas certificate, and people's safeguarding information was provided in the following weeks.

The provider's audit system was not effective, nor were the systems and processes regarding the checking in of medicines so we could not tell if there had been an excess of medicines when they were delivered or if the MAR had been signed and these medicines had not been given as required.

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

The provider had not notified CQC where Deprivation of Liberty Safeguards (DoLS) had been authorised for people as required, so that where needed, CQC can take follow-up action. For example, for one-person DoLS was authorised on 19th October 2017, another person's DoLS was authorised on 24th November 2017, and a

third person's DoLS was authorised on 05 February 2018. Following the inspection feedback, the provider had notified CQC.

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

The service did not have a registered manager in post. The current manager told us that the previous registered manager left the service in April 2018, and that they joined the service as a manager, two months ago. The head of operations said that the current manager, was in the process of making an application to CQC to become a registered manager. However, their application was not received at CQC.

The manager demonstrated good knowledge of people's needs and the needs of the staffing team. There was an out of hours on call system in place that ensured management support and advice was available to staff when required.

The manager held regular staff meetings. Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, coordination with health and social care professionals, and any changes or developments within the service. The provider sought people's views through the use of care reviews and satisfaction surveys, and the responses were all positive.

The service had a positive culture. The manager told us the service used staff induction and training to explain their organisational values to staff. We saw the manager interacted with staff in a positive and supportive manner. Staff described the leadership at the service positively. One member of staff told us, "So far so good. We have worked together for some months now."

The provider had worked effectively in partnership with a range of professionals. For example, health and social care professionals, commissioners, dieticians, community mental health team, psychiatrist, GPs, and hospital staff. Records we saw confirmed this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC where Deprivation of Liberty Safeguards (DoLS) had been authorised for people as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The premises were not safe. The provider did not meet the fire safety standards. The medicines were not managed safely. One person's bedroom had offensive odours. The provider did not manage accidents and incidents effectively to reduce the possibility of reoccurrence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The decoration and other adaptations to the premises did not help to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system and process to assess and monitor the quality of the care people received was not effective.