Hooton Chase Ltd

Hooton Chase

Inspection report

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Hooton
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Tel: 0151 327 4781

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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We carried out an unannounced inspection of Hooton Chase on 17 and 23 November 2015.

Hooton Chase is a detached property providing care for up to 12 people with learning difficulties. The building is arranged across two floors with a central staircase. There are 12 single rooms located across the ground and first floors. Parking is available at the front of the building.

There has not been a registered manager in post since March 2015. An application is being processed for a new registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection of Hooton Chase was carried out in October 2013 and we found that the service was meeting the regulations we reviewed.

Summary of findings

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered provider did not have a policy or procedure in place to ensure that the Mental Capacity Act was implemented. People were restricted from leaving the service on their own to ensure their safety and this had not always been done in line with the legal requirements.

People were not being supported to manage their own monies and the registered provider did this on their behalf. There was no evidence that people's consent had been sought regarding this matter.

The views of people and their relatives were not actively sought and people were not involved in decisions about the service. People were not involved in day to day decisions regarding the running of the service including menu planning, grocery shopping and the replacement of communal items.

There were insufficient staff employed at the service with a high reliance on permanent staff agreeing to work extra shifts, which meant the registered provider could not demonstrate that people were safe. Staff had not attended all necessary training and were not supported in their roles.

Incidents were recorded however people's care plans or risk assessments had not been reviewed or updated following these incidents. This meant that risks to people had not been considered and when appropriate, minimised.

The building was in need of repair due to a leak in the roof and concerns regarding severe condensation within a person's bedroom. The registered provider did not demonstrate that consideration had been given to the risks to people. Two ensuite bathrooms were awaiting refurbishment.

Monitoring systems were not effective in identifying areas for improvement and as a result, people's safety and the service they received was compromised.

Emergency procedures were inadequate to ensure people's safety. Routine checks on the services fire detection and management systems had not been completed. Not all staff were aware of what action they should take in the event of an emergency, placing them and people at risk of harm.

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 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?
The service was not safe.

Risks people faced were not identified and planned for. There were significant risks relating to the building and maintenance that was required.

Fire evacuation procedures had not taken place and there were no emergency contingency plans.

Staffing was not sufficient to meet the needs of people who used the service.

Inadequate

Is the service effective?
The service was not effective.

There was no evidence of mental capacity assessments or best interest decisions within people's care plan files.

People's finances were not managed in a way to promote their independence.

Staff did not have access to regular supervision and meetings with the manager.

Staff knew the people living at the service really well.

Inadequate

Is the service caring?
The service was not always caring.

People were not always informed of events in a way that they understood. This led to unanswered questions and confusion.

Incident reports used poor terminology and did not promote a person centred approach to care.

People and their relatives told us that staff were kind and caring.

We saw that people had developed positive relationships with staff who had a good understanding of their individual needs.

Requires improvement

Is the service responsive?
The service was not always responsive.

Information within the care plan files was not up to date and did not accurately reflect the support being offered.

The service was short staffed and totally reliant on permanent staff accepting overtime shifts to cover shortfalls.

People were not undertaking regular purposeful activities both within the home and in the community.

Requires improvement

Summary of findings

People and their relatives knew how to make a complaint and were confident that they would be listened to.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager in place.

There was a lack of effective quality assurance monitoring systems in place to ensure that improvements were made to the service people received.

The policies and procedures were out of date and required review.

People told us the manager was approachable.

Hooton Chase

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 17 and 23 November 2015 and was unannounced.

The inspection was carried out by an adult social care inspector.

Before the inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the registered provider had sent to us since the last inspection and information we received from members of the public, healthwatch, infection control and the local authority. We were provided with an infection control audit and a monitoring report, which had been carried out by the infection team from the local NHS foundation trust.

During the inspection we spoke with four people who lived at Hooton Chase and a visiting health care professional. We spoke with the manager and three members of staff. We reviewed three people’s care records in detail and observed how staff interacted with people in the communal areas. We also looked at four staff files and records relating to the management of the service including, policies and procedures, maintenance records and health and safety certificates.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said; "Yes I feel safe living here". A family member said that they felt their relative was safe living at the service.

Staff told us and records confirmed that most staff had received training in safeguarding and protecting people from harm. A safeguarding policy was available although required updating. Staff were knowledgeable in recognising signs of potential abuse and were able to tell us what they would do if they suspected anyone had suffered any kind of harm. However staff were unclear regarding the process to follow for reporting abuse or potential abuse . They said they would contact a manager but did not know how to directly report a concern to the local authority safeguarding team.This meant local safeguarding procedures may not be followed to keep people safe.

A fire alarm test and drill along with all other fire related safety checks had last taken place on 15 September 2015. The service policy stated the checks are to take place monthly. The registered provider was not following their own process to maintain people's safety. Evacuation procedures had not taken place outside daytime working hours.This was required to ensure the service had adequate systems in place for when there are only two staff in the building at night or at the weekend. Individual personal emergency evacuation plans (PEEPS) were in place. A contingency plan was not in place for staff to follow in the event of an emergency. This meant that should people not be able to re enter the building following an emergency evacuation they would not have an alternative arrangement for accommodation. An up to date fire risk assessment specific to the service was not in place leaving people at risk of harm. The fire service had undertaken a fire safety audit on 21 October 2015 and had highlighted areas of improvement that required actioning. Some of the actions to be addressed included improving the fire detection system,improving fire drills, maintenance to the fire alarm system and an independent fire safety risk assessment to be undertaken. The registered provider had not commenced any of the actions on the day of our visit.

Risks had not always been managed to keep people as safe as possible. Risk assessments had been completed although they did not evidence regular review or updates following changes in people's needs. This meant that staff did not have the information they required to ensure that people received safe care and support. One person who used the service experienced recent changes in their behaviour, which posed a risk to them and others; however the person's risk assessments had not been reviewed or updated to reflect this. This meant people were not being kept safe. A risk assessment reviewed on 2 January 2015 stated hot water temperatures at the service should be checked regularly. The hot water on a wash basin in a communal toilet was hot and the manager was asked to ensure this was addressed. The manager confirmed water temperatures had not been checked.

Accidents and incidents were not continually reviewed to identify and address patterns or common themes. They had not demonstrated consideration to minimise future risk or reduce the likelihood of reoccurrence.

Up to date policies, procedures and guidelines for infection control were not available on the day of our inspection. Systems were not in place at the service for deep cleaning furniture and specific areas including communal bathrooms, people's bedrooms and ensuites. There was no procedure in place should there be an outbreak of infection within the home. Night staff were required to follow a cleaning rota and complete records to show the tasks completed; however the records had not been completed consistently. Hand towels were not available within the communal toilets on either of the inspection visit dates. This meant people were not being protected against the risk of the spread of infection. Wall mounted soap dispensers and hand towels had been ordered and delivery was awaited.

The premises had not been cleaned effectively. There was a build up of lime scale around sinks and taps in bathrooms and toilets. Floors were not clean, particularly the tiled floor in the downstairs toilet. The chest freezers were unclean and packets of frozen food were not resealed after opening. There were a lot of crumbs evident. The drawers underneath the oven were very dirty and in need of deep cleaning. There was damage to a chair in the lounge which had its filling exposed and other seating showed signs of high wear and tear. All required hand hygiene products and personal protective equipment were not available for staff

Inadequate

Is the service safe?

use. This meant that people were not protected from the risk of infection because safe hygiene standards were not maintained. There was damage to one of the ensuite bathrooms and another was also awaiting refurbishment.

This was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) as the registered provider had not prevented, detected or controlled the spread of infection including healthcare associated infections.

Appliances such as a microwave oven and broken patio furniture were outside the property in areas accessible to people who used the service. Two fence panels were in need of replacement, one was missing and another was broken. This meant people were not kept free from harm. The health and safety checklist for the service was last completed in 2014. The manager confirmed this should be completed bi monthly. Areas of potential risk were not being identified, reviewed or action plans put in place to remedy health and safety alerts.

One person's bedroom ceiling had a leak and containers were in use to collect drips when it rained. This had been happening for at least six months and all repairs to date had been unsuccessful. There were not any risk assessments in place for this. This did not ensure people's safety when entering or leaving this person's bedroom. Another persons bedroom had condensation which was causing damage to their possessions. A treasured card from family members was soaking wet. This person said that they had also had to dispose of DVDs which had become damaged from the condensation. This was reported to the manager who confirmed it had been an ongoing issue.

This was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) as the registered provider had not ensured that the premises were safe to use for their intended purpose or used in a safe way.

Five people's medication administration records (MARs) were handwritten with instructions for the use of PRN medication; this is medication to be given when required. The records did not include people's names, description of medication, strength, dosage and frequency. Signatures were missing from the MAR sheets following the administration of people's medications which meant the service could not demonstrate that the administration of medication had taken place. PRN protocols had not been reviewed in accordance with the registered providers procedures for the use of PRN medication. This meant staff did not have the most up to date information to meet people's medication needs. Medications awaiting return to the pharmacy were stored in a room which was unlocked on two occasions during the inspection visit. They were accessible to people who used the service and could have caused harm. This meant that we could not be confident that medication was being managed safely or that people were receiving their medication as prescribed.

This was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) The registered provider had failed to ensure the proper and safe management of medicines.

The first aid box stored within the kitchen had out of date items in it and did not have sufficient stocks of essential items to respond to emergency situations. The manager confirmed an audit system was not in place to re-stock this and agreed it was not sufficient to meet the needs of people who used the service.

The recruitment procedure had not always been followed. This meant that one person had been employed before all of the relevant checks had been completed. One person did not have a recruitment or training file as they had transferred from another service owned by the same registered provider. The manager could not demonstrate that this person had been recruited safely and had undertaken all required training to follow safe working practices.

A system to make sure that there were enough staff available to meet peoples' needs at all times was not in operation. There were minimal staffing levels to ensure people's needs were met and people were unable to access activities outside of the service.

The staff rotas were being managed on a week to week basis. The manager was often part of the shift pattern, not allowing them any time to undertake daily managerial tasks. The service was totally reliant on staff accepting overtime shifts to cover the rostered hours. The manager was regularly in the building for at least 36 hours at a time including a night shift. Three staff were working over 50 hours every week on the four weeks of rota's overviewed. Staff had very little time to sit and talk to people because they only had time to attend to people's immediate physical care needs. In addition to caring for people, staff

Inadequate

Is the service safe?

were also required to complete household tasks including cooking, cleaning and laundry. Arrangements in place did not ensure that sufficient numbers of staff were deployed to ensure people's assessed needs were met.

This was a breach of Regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) as sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed.

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Inadequate

Is the service effective?

Our findings

We saw the daily menu records and observed a choice of meals being offered. We did not see any evidence of healthy options on the menu. Very little fresh fruit and vegetables were included as choices on the menu and there was no fresh fruit or vegetables available at the service. Most foods were purchased frozen or in tins. People told us that the food was okay and they always had two meals to choose from. People had access to drinks throughout the day as well as snacks.

The registered provider has a system of keyworkers who were linked with an individual person living at the service and had protected time each month to get to know them very well. The manager confirmed and records showed that monthly keyworker meetings had not taken place for at least three months. This meant that people were not receiving quality time with staff that knew them well. People had not been given the opportunity to plan their time and also discuss any concerns or worries. Monthly planners were not up to date showing people's planned activities. Staff spoken with said that this was because people could not go out to undertake activities due to the service being short staffed.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The manager and some staff had attended training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a basic understanding and awareness of the Act, for example, they asked people for their consent before carrying out tasks such as support with personal care.

The registered provider did not have a policy or procedure relating to the MCA requirements.

People's monies were managed by the service although the manager was unable to show any documentation supporting the best interest decisions regarding this. There was not any information available demonstrating any specific arrangements made with the bank to support this process. The registered provider held people's debit cards for safe keeping as well as their bank statements. Each person did have their own bank account and funds were stored separately. This meant people's independence was not being promoted. There was no evidence of mental capacity assessments or best interest decisions within the care plan files.

This was a breach of Regulation 13 safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure people were protected from abuse and improper treatment.

People were restricted from leaving the service on their own to ensure their safety; this had not always been done in line with the legal requirements. The manager confirmed that some of the people living at Hooton Chase needed deprivation of liberty applications to be in place; however this was not demonstrated within their care plans. The manager stated that this had not yet been done. This meant that people were being unlawfully deprived of their liberty and decisions were made on their behalf without following the correct procedures.

This was a breach of Regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not ensured service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

The registered provider did not have a training matrix or training plan to demonstrate training completed by staff and training required. Records of completed training were inconsistent throughout the staff files. One staff file stated most training had been completed during 2013. No specific training was identified or certificates of completion included. This meant the registered provider was unable to demonstrate that staff had the relevant skills to undertake their roles. There was evidence of recent computer based training taking place. Core training that most staff had completed included health and safety, moving and handling, fire safety, safeguarding and food hygiene.

Staff had not received regular supervision for their role. Records showed that staff had not had a formal one to one

supervision or an annual appraisal with their line manager this year. Supervision can support staff to develop their understanding and working practices. There was no system in place to review staff's training or learning and development needs. Staff supervision would ensure competence is maintained. Staff told us they could talk to the manager but as they are so short staffed the manager is generally part of the support team and on the daily rota. One staff member said, "If I have any problems I can always talk to the manager and a senior, they are very approachable". However staff also said that being short staffed was very stressful and was having a negative impact on the people who lived in the home, as they could not go out. We found that staff had not received the appropriate support, professional development and supervision they needed to carry out their role.

This was a breach of Regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not ensured that staff received appropriate support, training professional development, supervision and appraisal to enable them to carry out their duties.

Records did not show that people had regular access to healthcare professionals and had attended regular appointments about their health needs. Records showed that people had attended some appointments for the GP and dentist and when needed other relevant healthcare professionals. The manager was unable to confirm some medical appointments had taken place meaning they were unable to demonstrate people's health and wellbeing was being managed.

People were awaiting flu vaccinations but had not been able to access these due to minimal staffing levels. The manager was unable to confirm that a person's optician appointment had been attended which was due in 2014. This meant that people's health may be affected.

This was a breach of Regulation 9 person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the care and treatment must be appropriate, meet people's needs and reflect their preferences.

Staff knew the people living at the service very well. Staff said they had gained information about people from their care plan files, fellow staff and visiting relatives to establish a full understanding of peoples likes, dislikes, histories as well as knowledge and skills to manage people individually. Families spoken with confirmed the staff knew their relatives very well.

Requires improvement

Is the service caring?

Our findings

People told us positive things about the staff which included “The staff are good and kind, they talk to me”. A family member said my relative is “Well cared for and happy”.

Staff were observed being respectful of people’s privacy and knocked on bedroom doors before entering. We saw that staff called people by their preferred name and listened to what people wanted. We saw some positive interaction between one person and a member of staff. The interaction was light hearted and jovial. However the atmosphere on each day of inspection was flat and of low mood. Staff said they were extremely tired. All staff and people living at Hooton Chase commented negatively about the impact of being short staffed. Comments from people living at Hooton Chase included “We don’t go out much or enough as always short staffed”, a member of staff said “People have no quality of life”.

When the incident reports were reviewed for a person several inappropriate comments and terminology were found. The comments included "Told her to go upstairs" and "Sent upstairs to calm down”. This demonstrated that some staff were not always caring and did not show dignity or respect towards people who used the service. This was discussed in detail with the manager who confirmed they would take action to address this. People were not always treated with dignity and respect, undignified language was used within documentation.

This is a breach of regulation 10 dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider must make sure that they provide care and treatment in a way that ensures people’s dignity and treats them with respect at all times.

People told us they were not involved in the development of weekly menus or in the purchasing of items for the home including groceries. The residents guide states that “The menu will be compiled with the help of residents”.

People were encouraged to make choices. People were given choices about what they wanted to eat and drink and where they preferred to spend their time. Two people told us they liked to tidy their bedrooms to maintain their independence.

Information regarding advocacy services was available. The manager said that this service had not been accessed by any people recently.

Requires improvement

Is the service responsive?

Our findings

People told us they chose what time they got up and went to bed. A visiting health professional said that the staff are always accommodating and helpful. The front door is always answered promptly.

People who lived in the home told us the service was short staffed. Comments included "Because we are short staffed we can't go out as much, it's a shame", "Haven't been able to go to the club in Liverpool on the bus or train – can't go as short staffed", "The staff are very busy because the home is short staffed", "Don't get to go out much as always short staffed".

Staff spoken with and the manager also confirmed the service had been short staffed for at least two months. One staff member said "We are short staffed, working more hours and it is very stressful", another said "There are just not enough staff at the moment".

Some people relied upon staff to support them with their activities. Each person had a weekly planner of activities within their care file. However these had mostly not been completed and activities had not been undertaken. One person had an up to date planner as they undertook the same activities each week. The daily records did not reflect if the activities on the planner had taken place. The residents guide states; "The home will offer individual daily activity plans to include meaningful occupation, leisure activities, education, using community facilities and college and work placements". This meant the registered provider was not complying with their own guidelines and people's mental and physical wellbeing was not being supported.

The manager confirmed that people used to plan to go away on holiday. People would choose where they wanted to go and who would support them. They would then save for this out of their weekly monies. The manager said there was still money saved in people's bank accounts but no holidays have taken place since 2013. People said they would like to go on holiday but the service was short staffed.

One person enjoyed brushing up leaves and watering plants, they also enjoyed spending time in the greenhouse and shed. This person spoke positively about their enjoyment of this activity that they were able to undertake independently.

We looked at the care plans for three people who used the service. Care plans did not reflect people's current needs. People had allocated keyworkers however no keyworker monthly meetings had taken place since August this year; others took place in April and May 2015. Documents including care plan reviews were overdue, according to the documentation. Essential lifestyle plans, and action plans for a healthy lifestyle and staying safe were also due for review in May 2014. This meant people's information was not up to date or accurate and could lead to incorrect care and support.

One person required blended and mashed foods. The care plan stated they required monitoring due to the risk of choking, no evidence of this was found within the daily record documentation. Records did not accurately reflect what support staff said they were offering. The examples above showed that the provider was not providing care or activities for people in a responsive or person centred way.

This was a breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider must do everything reasonably practicable to make sure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences.

The registered provider had a process in place for the monthly recording of people's weights. This activity had not taken place since August 2015. The manager said that the scales were not working and had not yet been replaced. There were not any action plans in place or care plans reflecting the purpose of the weight management programme. This meant that if weight gain or weight loss was noted action may not be taken.

One person showed us their room which they said they were proud of. The room was personalised and staff had helped the person to decorate and furnish it in the way they wanted. Another person showed us their room and said they enjoyed looking after it and keeping it clean.

Relatives told us they would talk to the staff or the manager if they had any concerns. One person said "I would speak to the manager as they are approachable". Relatives knew how to raise concerns and were aware of the registered provider's complaints procedure.

Requires improvement

Is the service responsive?

The registered provider had a complaints procedure which was available to people who used the service and their families. There was no record of any complaints being received at the service.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager in place although the acting manager had submitted an application to CQC to become the registered manager. The last registered manager left the service in March 2015.

The registered provider did not have an effective system in place to assess and monitor the quality of the service that people received. For example, the auditing systems in place had failed to identify a need for risk assessments where there was a leak in a person's bedroom doorway. This had not been actioned in a timely way and there was a risk the person's health could have been compromised. One person's risk assessments and care plans had not been reviewed or updated following the completion of recent incident forms. The manager confirmed that audits had not taken place for several months due to staff shortages. This meant risks were not being identified and people were not being kept safe.

Medication audits were not being completed to identify any areas for improvement. Audits are undertaken to identify areas for development or improvement as well as identifying good practice. The registered provider was unable to demonstrate the quality of their medication procedures.

The manager could not demonstrate that all staff who administered medication had been trained and assessed as being competent. People were at risk of not receiving the medication they required.

A system to make sure that there were enough staff available to meet peoples' needs at all times was not in operation. There were minimal staffing levels to ensure people's needs were met and people were unable to access activities outside of the service.

The manager told us the last staff meeting took place in June 2015 although minutes were not available. There had been a minuted staff meeting held in January 2015. Staff told us they did not remember when the last staff meeting had been.

The system for managing people's financial affairs was not robust. There was no documentation in place supporting the practice of holding people's bank statements and all monies. People's independence was not being promoted.

The registered provider had a quality monitoring system in place which sought the views of staff, families, professionals and people that used the service. The last annual audit had taken place in October 2013. This meant the views of people were not being actively sought or acted upon. Records showed that residents meetings had not taken place. The manager confirmed residents meetings had not taken place this year.

The policies and procedures were produced in November 2013 with a review date of November 2014. The review of the policies and procedures had not taken place and was therefore overdue. The residents guide and statement of purpose refers to people's views that use the service will be sought for policy and procedure review. No evidence of this was seen.

The registered provider did not have a policy in place for the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS).

Accidents and incidents were recorded, however there was no evidence of analysis to determine any actions to be taken to minimise reoccurrence. This meant action may not be taken to prevent a reoccurrence.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. The registered provider did not have an established system or process in place to enable them to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. Nor had they maintained accurate records in respect of the service.

People told us they would speak to the manager if they had any problems. They also said there had been a lot of managers at Hooton Chase. Families said that the manager was approachable and knew their family members very well.

The manager had informed the CQC of specific events that they are required, by law to notify us about. They had reported some incidents to other agencies when necessary in order to keep people safe and well.