Optima Care Limited

The Chilterns

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**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 23 and 24 August 2018 and was unannounced.

The Chilterns is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Chilterns accommodates up to 26 people in three adapted adjoining buildings. At the time of the inspection there were 20 people living at the service.

There was no registered manager in post. The previous registered had left the service in July 2018. There was a manager in post who had started at the service on 1 August 2018 and would be registering with the Care Quality Commission. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations, about how the service is run.

We last inspected The Chilterns in August 2017 when a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. We issued a requirement notice in relation to staffing numbers. At this inspection, there was a continued breach of Regulation and three new breaches of Regulation.

At our last inspection, the service was rated 'Requires Improvement' overall with effective, caring and responsive being rated as Good. At this inspection, improvements had not been made and there continued to be breaches of regulation. Therefore, this is the third consecutive time the service has been rated Requires Improvement.

At our last inspection, there were not always sufficient staff to meet people's needs and enable them to always attend activities when they wanted. At this inspection, there continued to be times when there were not enough staff and people were not able to go out when they wanted.

Potential risks to people who had recently moved to the service, had not been consistently assessed and detailed guidance was not available for staff to follow to mitigate the risks. Some people displayed behaviour that may challenge the service or could become very anxious. Staff told us that they felt that they did not always know how to support these people. People were at risk of not receiving consistent support when they needed it. People who had lived at the service for a long time had detailed risk assessments and plans for staff to follow and support them so they remained safe and these had been effective.

Staff had met with people before they moved into the service, a comprehensive assessment was completed. The assessment covered all aspects of people's lives including their social, cultural and sexual orientation. This was used to develop a detailed support plan, however, recently this had not happened and people who had moved to the service did not have person centred care plans that gave details of their choices and

preferences. People who had lived at the service for a long time, had person centred plans that they had agreed to. The service had not supported anyone at the end of their lives, the service did not include end of life wishes in people's support plan.

Medicines were not always managed safely. Systems that were in place to identify when errors had been made had not been completed correctly and had not been effective in identifying shortfalls found at this inspection. Checks and audits had been completed on all aspects of the service including care plans. Shortfalls had been identified and an action plan put in place, but these had not been followed up and the shortfalls continued at the inspection.

The buildings had been adapted to meet people's needs, however, the dining room had been out of use since February 2018, as the ceiling had fallen down. People told us that they were unable to eat their meals together. People and staff had to go outside to enter the other buildings as they were not able to go through the dining room. Checks were completed on the environment and equipment used by people to keep people safe.

There was a training programme in place, however recently, not all staff had completed all the training that was available. There was a stable core staff team who knew people well and had completed the training previously and could describe how they supported people. Staff had received supervision and told us they felt supported by the manager. Staff were recruited safely.

People were encouraged to plan their care and express their views. 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.

People were supported to make complaints about the service, these were investigated following the provider's policy. People were involved in finding a resolution and the action taken to stop it happening again. Incidents were recorded and analysed to identify patterns and trends. This information was discussed in multi-disciplinary meetings and used to develop strategies and plans to mitigate the risk of them happening again.

People were supported to learn new skills such as cooking to increase their independence. People took part in activities and these were used to increase people's independence and confidence. People were encouraged to maintain a healthy and balanced diet. People told us how they had lost weight and stopped smoking. People were treated with kindness and compassion; strong relationships had been formed between staff and people.

Staff worked with other healthcare professionals to enable people to have the support they needed to live their lives to the full. Staff knew how to recognise the signs of abuse and knew how to report any concerns they may have. They were confident that the manager would deal with the concerns appropriately. The manager had reported concerns to the local safeguarding authority and worked with them to resolve the concerns.

The manager had a vision for the service; for 'The Chilterns to offer a range of psychological and skills based interventions to support service users to reach their full potential and maximise opportunities to live an independent life.' There was an open and transparent culture within the service, people knew the manager and were comfortable in their company.

People and staff attended meetings and completed surveys to give their opinions on the service and

improvements that could be made. The manager understood the need to continually improve the service and attend local forums to keep their knowledge up to date.

People were supported to keep their rooms clean and tidy. Communal areas were clean and odour free, staff used personal protective equipment when required to protect people from infection.

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 check that appropriate action had been taken. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall and on their website.

At this inspection a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and three additional breaches were identified. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not sufficient staff on duty to meet people's needs. Staff were recruited safely.

Potential risks had not been consistently assessed when new people came to live at the service, there was not always detailed guidance to mitigate the risk.

Medicines were not always managed safely.

People were protected from the risk of infection.

Environmental checks were completed to ensure people were safe.

Incidents were analysed and action taken to reduce the risk of them happening again.

Safeguarding concerns were reported and appropriate action taken to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The building was adapted to meet people's needs, however, not all areas of the service were able to be used.

People were supported to make their own decisions. Staff worked within the principles of the Mental Capacity Act 2005.

There was a training programme in place but not all staff had received all the training available.

People were supported to eat and drink enough and lead a healthier lifestyle.

People had access to healthcare professionals.

People's needs were assessed using recognised tools and covered all areas of people's lives.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider still needed to make improvements to staffing levels to consistently meet people's social needs.

People were treated with dignity and respect.

People were supported to be as independent as possible.

People were involved in planning their support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

New people living at the service did not always have personalised support plan that gave information about their choices and preferences.

People's end of life wishes had not been recorded.

People took part in activities that developed their skills for the future.

People knew how to complain and any complaints were investigated following the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post.

Audits and checks had identified shortfalls; however, the shortfalls had not been rectified and were identified at this inspection.

People and staff were involved in the development of the service.

The service worked well with other agencies.

The manager understood their responsibility to continue to learn and improve the service.

There was an open and transparent culture within the service and there was a clear vision to improve people's lives.

The Chilterns

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 0f the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 24 August 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector 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.

Due to technical problems, the provider was not able to complete the Provider Information Return. 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 looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We looked at seven people's care and support plans, associated risk assessments and medicines records. We looked at management records including recruitment files, training and support records, resident and staff meeting records, audits and quality assurance. We observed staff spending time with people.

We spoke with the manager, registered nurse, five care staff, activities co-ordinator and administrator. We spoke with ten people who live at the service. We did not use the Short Observational Framework for Inspection as people were able to speak to us about their experience living at the service.

Following the inspection, we received feedback from a social care professional.

Requires Improvement

Is the service safe?

Our findings

People told us that they did not always feel safe living at the service. One person told us, "I feel safe here, but when there is only one member of staff on the floor I feel vulnerable."

At our last inspection in August 2017, the provider had failed to have sufficient numbers of staff on duty to consistently to meet people's needs and keep people safe. At this inspection, improvements had not been made. There continued to be inconsistent numbers of care staff to support people when they needed it.

The duty rotas showed that the number of staff on duty varied widely, gaps were filled by bank and agency staff to ensure that the minimum number of staff were on duty. There were occasions when only half the staff on duty were permanent staff. Minimum staffing did not always enable people to go out and take part in activities. Previously, there had been a stable group of people living at the service but in the last six months, some people had left and others had come to live at the service. The needs of the people living at the service had changed but this had not been considered when assessing the number staff needed.

In one house, two people had been admitted, one requiring two staff to support them most of the time. There were three staff allocated to the house, when two staff were needed to support one person this left one member of staff for the five other people in the house. Staff told us, they felt this was unsafe, as the other people could display behaviours that challenged the service. One person told us, "The staff are busy now with a new person. They have less time for the rest of us."

There were not always enough staff to complete tasks such as medicines and managing people's money in a timely manner for people to go out when they wanted. There was often only one member of staff on duty to administer medicines across the three houses and this person was usually responsible for giving people their money to go out. One person had complained that they had been unable to go out when they wanted as they had to wait for their medicines and money. The manager had upheld the complaint.

The manager told us they were aware of the staffing issues. They were recruiting for staff that were flexible to meet people's needs and increasing the number of staff that could administer medicines.

The provider had failed to provide sufficient numbers of staff consistently to meet people's needs and keep them safe. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. There were systems in place for staff to record the number of tablets in boxes at each medicine round, to check that the numbers of tablets that were available in boxes were correct and that medicines were being given. These systems had not been effective.

One person was prescribed Sodium Valproate 500mg and 300mg, to manage epilepsy and Clozaril to treat schizophrenia. The number of tablets in the box did not match the number recorded by staff. There was one more 500mg tablet and one less 300mg tablet than there should be, there was one less Clozaril than there

should be. These medicines had not been given as prescribed.

To minimise the risk of people being given the wrong medicine, it is best practice to separate medicine administration record (MAR) with a divider. These should include essential information such as allergies and the person's photo. The majority of MAR's had this, however, some did not and people's MAR charts were not separated, there was a risk people could be given the wrong medicine.

The provider had failed to consistently manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely. The temperature of the room and fridge where medicines were stored was recorded and was within safe limits to ensure that medicines remained effective. Some people were prescribed medicines on an 'when needed' basis. There was guidance in place for staff to follow about when to give these medicines. People's medicines were reviewed regularly by their doctor.

Potential risks to people's health and safety had not been consistently assessed and there was not always detailed guidance for staff to follow. Some new people had been admitted to the service, there were documents in their support folders that included details about people's needs, behaviour and risks. However, these documents were long and did not include guidance about how to support people and manage the risks. Staff told us that they felt unsure about how to support new people as they did not have clear written guidance to follow about how to recognise triggers and how to manage people's behaviour.

Other new admissions had a transition plan, this included information about identified risks and the signs and symptoms when people were becoming unwell. There was some guidance but this was not detailed and clear. For example, 'Staff to scale down on prompting personal hygiene, as well as being more tolerant of pulling back.' There was no explanation of what this meant. There was a risk that staff would provide inconsistent support to people.

The provider had failed to consistently assess the risks to the health and safety of some new admissions and do all that is reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who had lived at the service longer had detailed risk assessments and detailed guidance about how to support people when displaying behaviours that may challenge the service or others. Staff completed training about behaviour management. Staff were trained in 'therapeutic management of violence and aggression' (TMVA). TMVA provided solution to all levels of challenging behaviour, with emphasis being on de-escalation. Staff explained how they supported people and when they used TMVA, there was clear guidance for staff about when to use the intervention and how to intervene. TMVA plans were developed with the in-house trainer, who had oversight of staff training and assessing when TMVA was used, if it was appropriate and applied correctly.

Incidents were recorded and analysed. Staff completed behaviour charts, so that specific behaviour could be identified and strategies put in place to minimise the risk of them happening again. Reports of incidents were reviewed at the person's multi-disciplinary meeting and any support needed was agreed with the person. Changes were communicated to staff at verbal handovers at the change of each shift.

People were protected against the risk of abuse. There was an open and transparent culture about reporting any concerns or incidents. The service worked with the local safeguarding authority when concerns were raised. A social care professional told us that the service dealt with concerns immediately and took

appropriate action. Staff supported people to raise any concerns they had with the appropriate authorities including the police.

Staff were recruited safely. Checks were completed to ensure staff were of good character and suitable for their role. Checks included a full employment history, two written references and an interview. Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were protected from the risk of infection. Staff had completed infection control training and used personal protective equipment when required. Domestic staff were employed to clean communal areas. People were supported to clean their own rooms and do their own washing.

There were regular checks on the environment to ensure people were safe. Checks on fire equipment were completed, improvements requested by the local fire and rescue service had been completed. Regular checks had been completed on electrical and gas appliances to ensure they were safe to use.

Requires Improvement

Is the service effective?

Our findings

People told us that they enjoyed the food and staff received training. One person told us, "I have never had better food. We have a choice of two meals on the day." Another person told us, "The staff know what they are doing."

The service supported people living in three connected houses. The houses had been adapted to meet people's needs. However, the dining room that was used by people living in two of the houses, had not been fit to use since February 2018. Due to issues with the plumbing in the room above, the ceiling had fallen. The manager told us that that the work had not been completed due to problems with the builders

The dining room was the social meeting room for people, they were now unable to eat their meals together. People told us that they were missing the social contact of being able to eat their meals together. The dining room being closed meant that people and staff were unable to move between the two buildings without going outside. Some people needed to use a washing machine with a specific wash programme and had to carry their washing outside the building.

The provider had failed to properly maintain the service. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a training programme in place, staff had received training appropriate to their role. This included mandatory subjects such as health and safety, safeguarding and mental capacity. Staff received training in specialist subjects relevant to the people they supported such as epilepsy and behaviours that challenged.

Staff training was recorded on a chart; however, this had not been kept up to date. The chart showed that a new member of care staff and two long standing care staff had not received some training such as equality and diversity and food hygiene. The manager confirmed that they could not find certificates to confirm that they had attended the training. The new member of staff was due to complete their training shortly after the inspection. Long standing staff described to us how they supported people safely and confirmed that they had received training updates.

New staff completed an induction, this included basic training and shadowing more experienced staff to get to know people and their choices and preferences. Staff competency was checked to make sure they had the right skills to support people. People told us that staff were trained and supported them as they wanted.

Staff received supervision. This had not been recorded regularly but staff told us that they had felt supported. They were unsure about the future as there had been a change in manager and one of the nurses had left. Staff had not received regular appraisals to discuss their performance and development, this was an area for improvement.

Before coming to live at the service people met with the manager or regional manager to discuss their needs and to decide if the staff would be able to meet their needs. The assessment covered all areas of the

person's life including psychological and any behaviours or triggers they may have.

People's needs were assessed using recognised tools and following best practice guidelines. People could spend time at the service before they moved in permanently, a plan would be devised to help people make the transition to living at the service. The plan could include day visits and overnight stays.

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 make 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 so that they can 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. Some people living at The Chilterns had authorised DoLS in place and these were kept under regular review to make sure they were still necessary. Any conditions imposed under the DoLS were being complied with.

Other people were subject to restrictions under different legal frameworks. Staff were aware of these restrictions and supported people to understand the restrictions. Staff supported people to make decisions and choices about how they lived within any restrictions imposed. When people had restrictions in place, for example, access to technology, people agreed to a plan to keep people as independent as possible within the restriction.

Regular multi-disciplinary meetings were held which people were encouraged to be part of. These meetings made decisions about people's care and support and people were part of any decisions made. People could discuss any changes in their support and their input and agreement was recorded. When people did not have the capacity to make complex decisions, meetings would be held with the person and their representatives to ensure that any decisions made were in their best interests.

People told us that they liked the food and that they were given a choice. The manager told us that they wanted people to be more involved in choosing the menu in the future. Some people had developed their skills to be able to cook simple meals and staff supported them to do this.

Staff supported people to make healthy choices with their meals and snacks. Some people had decided they wanted to lose weight, they were supported to increase their exercise and eat healthier meals. People were supported to take part in activities such as swimming, walking and cycling and to stop smoking. One person told us how pleased they were as they had lost weight and had stopped smoking for ten weeks.

People were encouraged and supported to attend appointments with the GP, dentist and optician when needed. People had detailed healthcare passports. These gave an overview of people's health needs and the medicines they were receiving. Staff monitored people's health and made referrals to healthcare specialists when required such as dieticians. The guidance from the healthcare professionals was recorded and followed by the staff.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind but there was not enough of them and they did not always do the activities they enjoyed. One person told us, "The staff are kind to me. There are not always enough staff, so I can not go to the disco or do other activities." Another person told us, "The staff have done a lot for me. They respect me and knock on my door."

We expect provider's to be caring in the way they provide resources including staff to meet people's needs and support them to in all aspects of their lives. At the last inspection, there were not sufficient numbers of staff to meet people's needs. At this inspection, the situation had not changed. People and staff told us and records confirmed that the level of staffing had not changed and there were now more people living at the service and people were not always able to take part in the activities they wanted.

There were supportive relationships between staff and people who had lived at the service for a long time. People had built trust with established members of staff, we observed people chatting with staff and laughing. Staff supported people when they were anxious and upset, we observed this during the inspection, staff spoke to people in a kind and compassionate way. Staff listened to people and were interested in what people had to say.

People told us that they felt understood by staff who they had worked with to establish strategies and risk management plans. People had become more independent and there was positive impact on their lives. Some people had set a goal to be able to go into the community independently, staff had supported people and they were now able to go to designated local places for periods of time independently.

The service used a 'fob' key to unlock doors and enable people to move around the service. Each person was given a fob, this was programmed specifically for each person, as to the areas they were permitted to go into and between which times. When people had been assessed as safe to leave the service they had fobs that let them out of the service. This enabled people to be as independent as possible.

People were involved in planning their support. Staff encouraged them to take responsibility for their actions and understand their feelings. People were involved in planning their goals and objectives, within the restrictions of their legal framework. Staff developed plans with people and these were regularly reviewed and altered as needed.

People were supported to maintain relationships with people that were important to them. One person told us, "I go home each weekend Friday to Sunday. The staff drop me off." We were invited to visit people's bedrooms. People had been encouraged to personalise and keep their rooms tidy.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. There were easy read documents available to support people to

understand all aspects of their support including the medicines they were prescribed.

Requires Improvement

Is the service responsive?

Our findings

People told us they could take part in activities and were encouraged to increase their skills. One person told us, "I go to college Adult Education. I study English and maths." Another person told us, "I go out on my bike, play football each week. There is a gardening club I am involved in."

People who had recently moved into the service did not have personalised care plans. There was information available and this included all aspects of their care and support including their mental health, behaviour and sexuality. Some people had a transitional support plan giving some information about how to support the person, but this did not include their choices and preferences. The transitional plans had not been agreed by the person.

Staff had completed daily notes giving information about how they had responded and supported the new people when they became anxious or upset, and they had responded well. However, there was a risk that without clear guidance, they would not be supported as they preferred and the support staff provided would not be consistent and effective.

The service was supporting younger people who did not want to discuss their end of life wishes. The format that the service used to develop a support plan did not include discussing end of life wishes. People living at the service were living with complex mental health and physical issues which could affect their wellbeing at any time. Staff would not be able to support people in the way they would prefer.

The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who had lived at the service for a long time, had detailed support plans that reflected their needs, preferences and choices. People had signed the support plans to say they agreed to the plan. The plans were reviewed at multi-disciplinary meetings, which people attended. People were encouraged to discuss changes they wanted made to the plan. These changes would be made temporarily and reviewed to assess if they had been successful or not. During the inspection, we observed staff responding to people's social and emotional needs.

There was an activities co-ordinator and people were supported to take part in a variety of activities, when there were enough staff. These included groups and activities outside of the service. People told us they enjoyed the activities and these were designed around people's interests. There were group activities available but people's activity plan was personalised for them. The activities co-ordinator told us that they would alter the activities if there were not enough staff to support people.

There were risk assessments in place for activities and strategies had been put in place to enable people to take part in the activities they wanted. The activities were used to promote people's independence, for example, people were escorted in the community and gradually able to go to specific places independently.

People were supported to learn new skills for their future including cooking.

People told us they knew how to complain. There were complaints and compliments forms available in communal areas, and people were supported to complete these. The policy was available in an easy read format. The provider had a complaints policy, this was displayed around the service. When people made complaints, they were investigated in line with the provider's policy. All complaints were recorded along with the outcomes. People were supported to make complaints to outside agencies including safeguarding when they requested this.

Requires Improvement

Is the service well-led?

Our findings

People told us that they knew who the manager was and were asked their opinions. One person told us, "The manager came and introduced themselves." Another told us, "I really like the new manager. They are kind, polite, caring and really listens to you."

At the last inspection, the provider had failed to have sufficient staff to meet people's needs. This continued at this inspection, no improvement had been made and this was a continued breach. An additional three breaches of regulations were identified at this inspection.

There was no registered manager in post. The previous registered manager had left the service in July 2018. The new manager had started at the service on 1 August 2018. Other senior staff had recently left the service including a registered mental nurse and had not been replaced. The responsibilities of the people that had left were being undertaken by other staff, but had not always been completed in a timely manner due to their increased workload.

Checks and audits had been completed on the quality of the service including support plans and medicines. These checks had identified shortfalls, an action plan had been put in place but the action had not been completed as these shortfalls were still present at the inspection. For example, shortfalls had been found in the quality of the support plans and these had not been rectified. People who had recently moved into the service did not have personalised support plans. Potential risks to their health and welfare had not been consistently assessed and there was no detailed guidance for staff to mitigate the risk.

Systems had been put in place to identify when errors had been made in medicine administration quickly and manage staff training. These systems had not been monitored and had not been effective as shortfalls were found at this inspection.

The dining room ceiling had fallen in February 2018 and had not been repaired. This had affected people's lifestyle as they were unable to eat meals together and had to go outside to move between two of the houses.

The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate, complete and accurate records for each person. The provider had failed to improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had assessed the quality of the service when they started at the service, they were aware of the shortfalls that were found. We discussed this with the manager who told us that the provider was completing an audit of the service the following week and an action plan would be devised.

There continued to be an open and transparent culture within the service. The manager knew people and their backgrounds. During the inspection, people were comfortable with the manager and approached them

with any concerns they had. Staff told us that the manager had been happy to discuss their concerns with them since they had arrived and checked staff were managing during the weekend and night shifts.

People and staff had been asked their opinions about the service at regular meetings. House meetings were held, where staff supported people to discuss issues that were affecting them, such as people not cleaning the house kitchen. People made suggestions about what they would like and how the service could be improved including the menu and these were put in place.

Staff attended meetings where their practice was discussed and they were reminded about their responsibilities towards the people they support. Staff could discuss their training needs and any concerns they may have.

People had been asked to complete a quality assurance survey, at the inspection the results had only just been received and had not been analysed. Staff had completed a staff survey in December 2017, this had been analysed and a development plan had been developed. However, some of the plan had not yet been implemented as there still was not enough staff for people to always complete activities when they wanted.

The manager had a vision for the service, 'The Chilterns will offer a range of psychological and skills based interventions to support service users to reach their full potential and maximise opportunities to live an independent life.' The manager described how they wanted to support people to be as independent as possible.

The manager had not had the opportunity to attend local forums and manager's groups since starting at the service. They understood the importance of continually learning and involving other agencies and specialists to improve the service and support people. The manager had worked with the local safeguarding team since starting at the service.

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 check that appropriate action had been taken. The service had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

It is a legal requirement that a provider's latest CQC report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception of the service and on their website.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to consistently assess the risks to the health and safety of some new admissions and do all that is reasonably practicable to mitigate risks. Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to properly maintain the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate, complete and accurate records for each person. The provider had failed to improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide sufficient numbers of staff consistently to meet people's needs and keep them safe.