Delphside Limited

Avondale Mental Healthcare Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Avondale Mental Healthcare Centre offers support for up to 51 people whose needs are associated with their mental health. Staff provide support for adults of all ages which included 24 hour long term care, short term care, respite or assessment periods. Avondale is a purpose built facility, in a residential area of Whiston which is close to public transport routes.

This was an unannounced inspection on the 23 March 2016 and 29 March 2016carried out by an Adult Social Care inspector, Specialist Advisor (SpA) for mental health and a bank inspector. During the inspection we spoke with nine people who lived at the service, 12 members of staff, a member of the board of directors, the registered manager and the registered provider. 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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found breaches of Regulations 9, 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The registered provider had not followed the requirements of the Mental Capacity Act 2005 (MCA). Staff were not provided with the correct instructions and did not demonstrate that they knew how to apply the Act to support people with making their own decisions.

Staff supervision was not always consistent at the service. Some of the staff we spoke with said they had not received supervision for some time.

People did not receive care and treatment that was safe and were at risk from care practices. Risks were not appropriately determined and actioned. We saw that physical needs such as the management of diabetes and wound care were not fully assessed, planned or monitored to ensure that physical needs were safely managed.

People told us that they had been included in the planning and had agreed to the care and support provided. We saw that people had a plan which outlined some of the ways staff were to support them. Risks were not always addressed in order to fully maintain the safety of people. The care and support provided centred around tasks and not the individual care needs of people living at the service. We saw that restrictive practice or intervention that limited peoples movements or support were not fully assessed to determine that they were justified.

Some of the systems used to assess the quality of the service had not identified the issues that we found during the inspection.

People told us that they were treated with kindness, compassion and respect. We saw positive interactions

and observed that people enjoyed talking to the staff in the service. We observed that staff took the time to get to know people and supported them in undertaking activities. People told us they were able to see their friends and families whenever they wanted. We saw that there were arrangements in place to support people living in the service to access the community and maintain relationships with their families.

Systems were in place that supported and encouraged people to share their views of the service they received.

The staff told us they were aware of their responsibility to protect people from harm or abuse. They knew the action to be taken if they were concerned about the safety or welfare of an individual. They told us they would be confident in reporting any concerns to the management team.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The service had made DoLS applications as required.

Significant improvements had been made in the management of medicines. People received their medicines as they were prescribed for them.

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.

Risks to people were not assessed appropriately which placed people at risk of receiving unsafe or inappropriate care and treatment.

There were enough staff in place to ensure people received appropriate support to meet their care needs.

Recruitment records showed staff were checked appropriately before they started working in the service.

All staff working in the service knew how to recognised and report abuse.

Is the service effective?

Inadequate

The service was not effective.

Staff did not promote and develop the independence skills of people living in the service. There was limited assessment of the skills people had in order to plan appropriately to develop their independent living skills.

There was a limited understanding and implementation of the Mental Capacity Act 2005 and how to ensure the rights of people to make decisions were respected.

Arrangements were in place to request heath, social and medical support to help people stay well.

We found the registered provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always aware of people's individual skills, backgrounds and personalities. We observed that person centred care and support was not always available.

People's rights to privacy and dignity were respected.

People told us they were happy with the care and support they received and their needs were met.

People were supported by staff that were caring and kind.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's health, care and support needs were not always appropriately assessed. Individual choices and preferences were discussed with people who used the service. However these discussions were not reflected in people's care records in order to make sure consistent and appropriate support was delivered.

Family members and friends played an important role and people spent time with them.

People told us they felt confident to raise any concerns and their opinions would be listened to.

Is the service well-led?

Requires Improvement

This service was not always well led.

The provider had not notified us of incidents they were required to inform us about.

There were limited systems in place to monitor the quality of the service. We identified gaps in these systems that had not ensured that the quality of the service was addressed and improved.

The registered manager and registered provider were well respected by all staff and importantly by people living in the service.

People who were able to express a view were supported to express their opinions about the service provided and to influence service delivery.

Avondale Mental Healthcare Centre

Detailed findings

Background to this inspection

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

This inspection took place on 23 March 2016 and 29 March 2016 and was unannounced. This was an unannounced inspection carried out by an adult social care inspector, Specialist Advisor (SpA) for mental health and a bank inspector.

Before the inspection we, reviewed all the information we already held about the service. We spoke with St Helens and Knowsley Council who stated that they did have concerns in relation to the service. In particular in relation to medicines both St Helens and Knowsley Council had provided support to the service.

During our inspection we observed how the staff interacted with the people who lived in the service. We observed how people were supported throughout the day. We reviewed ten care records, four staff recruitment records, staff training records and records relating to the management of the service which included audits, policies and procedures. During the inspection we spoke with nine people who lived at the service, 12 members of staff, a member of the board of directors, the registered manager and the registered provider.

Requires Improvement

Is the service safe?

Our findings

We asked all the people we spoke with if they felt safe. They all informed us that they did. One person said "Yes, I do feel very safe. I feel safer here than I have for several years. Staff are always around and I know I can go to them if I want anything". People told us they would be confident speaking to any member of the staff team, the registered manager or board of directors members. They all told us that they believed that any concerns they had would be dealt with appropriately.

We looked at how the registered provider managed risks to people living at the service. We saw that risk assessments were not always available in care records. We saw that one person managed a component of their medicines themselves. There was no risk assessment available for this or an explanation as to what support staff needed to do to minimise any potential risks.
We saw that where people were assessed as having a history of potential self-harm or attempted suicide there was no information within the care records as to how staff were to identify, manage and monitor any of these risks. We discussed this with the management team who were aware of peoples history but acknowledged there were no risk assessments in place or plans as to how potential risks would be reduced.

Several of the people we spoke with told us that they were "unhappy" with other people smoking as this was not always in the designated areas outside the service. We noted on a few occasions that there was a smell of cigarette smoke in the main corridors. The management team explained there was a difficulty in making sure the people adhered to the no smoking policy. There was a fire risk assessment in place but this did not reflect the difficulties that the service had in enforcing a no smoking ban or how they were to manage the potential risks that this could cause.

This was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not made sure that care and treatment was provided in a safe way to people in their care.

Staff spoken with told us they had completed training to support people's safely, recognise and report abuse, and knew the actions to take if they were concerned that a person was at risk of harm. During discussions staff members were able to detail what action they needed to take and how they would deal with any incidents of alleged abuse. They all expressed confidence that the management of the service would react to any allegations of abuse appropriately.

We looked at how the service recruited staff safely. We saw that there were appropriate checks undertaken before any staff member started working at the service maintaining the safety of people living there.

We reviewed arrangements for medicines and found that the service had made significant steps in making their system safer. A review of the Medication Administration Records (MAR) showed that good practice was in place but this was not consistent. As an example we saw that one person had refused a medicine but staff had taken appropriate action and returned to the person later in the day making sure that it was offered again. We also saw that this good practice was not consistent one person had not been given the

opportunity to take their medicine when they went out for the day. The medicine was prescribed for three times a day. Arrangements had not been made to make sure the person received all their prescribed medicines that day. There was information available to inform staff, when to give as 'needed medication' (PRN). We saw that this did not fully cover all the practices in place and some PRN medicines were not listed.

It is recommended that the registered provider updates their policies and procedures in line with the NICE guidelines [SC1] Managing medicines in care homes published March 2014.

During most of our time in the service we were told by people that the staff provided the support they needed, when they required it. Records in place in the service did not reflect this. We saw that one person needed additional support for a period of time on a one to one basis. There were no records that showed that this support had been put into place.

We discussed the arrangements for the service to test and make sure that legionella infection risks were identified and actioned. We saw that there had been a full report undertaken by an external company to check on the safety of the service in relation to legionella and appropriate actions taken.

Our observations of the building showed it to be well maintained and clean. There were checks on the hygiene of the service. We saw during our visit that the staff used appropriate personal protection equipment such as gloves and plastic aprons. We looked at the Kitchen and laundry and saw that appropriate checks and equipment were in place to maintain hygiene.

Inadequate

Is the service effective?

Our findings

We spoke with people who lived in in the service. They told us that they had been involved in developing their care plans and had either visited or a relative had visited the service before they moved in. One person told us, "My wife had looked carefully at the suitability of the home before I arrived and had been very happy with the care given since." People told us the food in at the service was good and enjoyable.

We checked how the service followed the principles of the Mental Capacity Act and its associated code of practice (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We looked at care records and found that the principles of the Mental Capacity Act 2005 Code of Practice were not followed.

The registered manager discussed their understanding of the Mental Capacity Act 2005 and its associated codes of practice. They had made appropriate referrals to social services using Deprivation of Liberty Safeguards (DoLS). Records were available for the people who had to have safeguards in place due to their capacity needs. When we spoke with staff they were unaware of which of the people they supported had a DoLs order in place. Staff need to be fully informed of this in order to support peoples appropriately.

The care records reviewed did not include information regarding a person's mental capacity. We saw in one instance that a person received covert medicines. Covert medicines are medicines that are "hidden" from the person and they are not aware that they are taking them. We looked at the records regarding this and saw that there had not been a capacity assessment to determine if the person lacked capacity to agree to the medicines. There had also not been a best interests meeting to determine if covert medicines were in the persons best interests and which medicines could be given covertly. There was no care plans in place that explained the actions staff needed to take before giving covert medicines in order to maintain the rights of the person. At the second day of our inspection the service had ceased giving out medicines covertly and the person was receiving medicines. Arrangements had been made to manage the person's medicines in line with their rights in the future.

We saw that there were a variety of consent forms signed by people using the service. In discussion with staff they explained that the consent forms were not always explained to people in order for them to be fully aware what they were consenting too. Additionally none of the consent forms were updated or reviewed to make sure that appropriate consent was still valid. The care records we reviewed were on occasions signed by relatives as giving consent to the care the person was to receive.

We were unable to locate any confirmation that relatives had the legal right to consent for people. Staff working in the service confirmed they did not seek legal confirmation that a relative had the right to consent to a person's care. We spoke with staff about how they made sure that care plans were understood by people living in the service. They explained that they did involve them in reviews but accepted that for

people who lacked capacity or whose capacity fluctuated, these were not always explained in a meaningful way.

In order for people to be give a full and valid consent they need to have information in a format that meets their needs. We saw that care records were not in a variety of different formats. We spoke with senior staff who confirmed that some people living in the service would have difficulty understanding the care records in the format that was available. We saw that there was limited guidance available in people's care records regarding how people were to be supported to make decisions, or how decisions were to be made where someone lacked capacity. As a result, staff were not always clear about how they were meeting their responsibilities under this legislation.

An agreement not to resuscitate a person (DNAR) was in place; however this was out of date. There were no records that the person's family had been consulted with or other relevant parties that this action was in the persons best interests. We also saw that there were no record of an assessments that the person themselves was unable to consent to a DNAR being in place. As a result the person's rights had not been maintained.

We observed how staff approached people with variable mental capacity in order to involve them in their care and gain consent. We saw that staff were not consistent in their approach. For example, some staff explained to people the meal available that day others did not.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the service.

We looked at how the service managed the training and competency of staff. We were informed that staff who gave out medicines had all received training and competency assessments. The training matrix for the service and planned training did not list eight nursing staff responsible for giving out medicines; three of these staff had no record of medicines training in 2016. We were informed that although competency assessments were undertaken these were not formalised.

Care records reflected a number of potential health risks such as wound care and the management of diabetes. We saw that these risks were not recognised, planned for or addressed within the care records. There were no care plans, wound monitoring or any records in place that showed that staff monitored the care of wounds for two people. We were informed by the registered manager and the clinical manager that the nursing staff within the service did not believe that they had the correct skills to manage wound care appropriately. They also stated that staff did replace dressings if they were lost or stained. However there were no instructions in any of the care records we viewed that informed staff what dressings they were to use in these circumstances. As a result external nursing staff were attending the service to redress all peoples wounds. The clinical manager explained that they intended to give the nursing staff training in wound care but as yet this had not taken place.

We saw that were people were assessed as being at high risk of developing pressure ulcers. There were no arrangements within the service that monitored people's skin and assisted in reducing risks to people determined at risk of developing pressure ulcers. Additionally we saw that although staff monitored the risk for people with diabetes by checking their blood sugar levels there was no guidance in people's care records as to what range was acceptable for them as an individual. As a result the monitoring of people's blood sugar levels had limited value in managing their care. One person was receiving a specific dose of insulin however there was no records to show that the dose of insulin in use was prescribed at that level. Staff spoken with were unable to locate the relevant record but explained that this was the correct dose. We

asked the registered manager that the service contact the person's doctor to make sure that they received written confirmation that this was the correct dose as the staff believed it to be.

This was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not made sure that care and treatment was provided in a safe way to people in their care.

A review of staff training showed that these was out of date or not in place. We were shown a training matrix for 2015 to 2016, which showed that 53 staff were employed and training matrix for 2016 to 2017 showed 52 staff were employed. There were gaps in the training that had not been filled in, as an example 2015 to 2016 one member of staff had received training in mental capacity act. From 2016 to 2017 three further staff had received mental capacity act training. The planned training for 2016 did not list any member of staff to receive mental capacity act training as a result there was four people who had received this training and no plans to increase this.

Our observations and review of records showed that the service was not appropriately ensuring that people's rights in relation to the mental capacity were in place. We were informed by the registered manager and clinical manager that the training matrix was out of date and that planned training needed to be increased.

There was a supervision policy in place. However, the majority of staff informed us they had not received any formal supervision. We were given a supervision matrix which listed a total of nine staff with supervision dates due after the inspection. Staff were not receiving formal supervision on an on-going basis in line with the services own policy and procedure.

We looked at how staff were inducted at the service. In all cases, an induction record was signed by the person undertaking the induction and the person being inducted. There was no evidence that although the induction had occurred that staff understood this training and were now competent. Additionally the induction was a general induction that orientated the new staff to the building and practices of the service but would have been unable to give staff the specific understanding they would need in their job role to meet peoples individual needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have sufficient arrangements in place to ensure that that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service.

We looked at how the service had been adapted to meet the variety of needs of people living there. There was limited indicators for people living in the service that would assist them to navigate around the service independently. Although the service is predominately for people with a mental health needs there were people living with dementia. The registered manager explained that the main corridors were being redecorated and they anticipated more pictures etc. would be in place shortly. There was no evidence that the people living in the service had been consulted as to their choice of décor. The registered manager gave reassurances that they did always discuss the choice of décor with people who lived in the service.

There was a newly refurbished activities room that was well used during our inspection. Additionally the service had an occupational therapy area that consisted of a kitchen and seating area. The intention of which was to support people to develop their independence skills. This was a resource that was under used as it was locked and not accessible directly from the service.

Bedrooms all had the ability to lock independently and a key given to people using the service. We saw that the majority of people's doors were locked to support them to maintain a private space. We asked permission to view peoples bedrooms. We saw that they were personalised with items of their choice. In some cases people were supported to have a kettle and a fridge in their bedrooms in order that they could make their own drinks and snacks.

Requires Improvement

Is the service caring?

Our findings

People we spoke with made positive comments about the support provided by the service. None of the people who lived at the service or the staff we spoke with raised any concerns about the quality of the care. They told us the staff were very caring and always treated them with respect.

Staff told us that they understood their responsibility to maintain people's confidentiality. They told us that information was kept safe and secure.
At our inspection we saw that the majority of the time people were spoken with in a caring and kind way. The staff were friendly, patient and discreet when they provided support to people. We saw that staff took the time to speak with people as they supported them. We saw staff laughing and joking with people and how people responded positively to this interaction. It was clear that people who lived in the service felt comfortable with staff. However we saw that this good practice was not consistent.

We observed the lunch being served in the main dining room, which was light and spacious. Our impression was that the service was not organised, with half a dozen people gathered around each trolley waiting to be served where hot food put people at risk of harm.

We saw people being offered their dessert before they had finished their main course with no communication between the staff member and the person. One person was served their dessert before being asked whether they wanted cream with it, this was after the cream had already been put over the dessert. Another person entered the dining room at 12.55pm; some 25 minutes after service had begun. There was no main meal available in either of the two trolleys, but before going off to the kitchen, the carer served the dessert. The person was served a meal from the kitchen however their dessert was left to go cold while they ate their main course. Fresh fruit was offered as an alternative to the two hot desserts. No hot drinks were offered and the whole process took approximately 35 minutes. Staff began to sweep the floor before some people had finished their lunch. We found this to be a regimented process, which although people seemed to enjoy, could not have been described as a pleasant experience.

We observed that people spent time in the communal lounges according to their wishes. People were able to walk freely around the service and garden. People living in the service told us that they did not have set routines and got up and went to bed when they wanted to as an example.

Staff explained that a key worker system was in place. A staff member is linked to a small number of people who use the service. They were encouraged to get to know each person, to understand their preferences and to make sure that their support plans reflect their needs and wishes. People we spoke with confirmed they knew who their keyworker was.

The service has a policy of no restraints which means that staff will always endeavoured to make sure people's behavioural needs were addressed and managed before they become a danger to themselves and others. Staff had access to personal alarms should they need them, the majority chose not to carry them. They explained, they felt confident in their own safety and when assisting people to manage their behaviour.

Requires Improvement

Is the service responsive?

Our findings

Several people we spoke with told us that sometimes the things that they wanted to do were restricted as staff were not available. One person told us they had wanted to play football but there was insufficient staff to do so. Another told us that they had wanted to play bingo in Huyton but they were told this was not possible. In their view this made "It difficult to motivate people as this was happening regularly". They told us "The nurses constantly seemed to be doing medication rounds, which tended to put more pressure on the carer". They told us that they had been told by the nurses that they would like to get more involved with the people living at the service, but did not have the time.

Several people told us that they were not happy regarding the arrangements of a vending machine that supplied drinks and snacks. One person told us that the vending machines had recently been moved from the activities room to the dining room, which had subsequently been locked between meal times. They had requested the doors to be unlocked, but had been told, "No, if we do it for you, we will have to do it for everyone." The management team explained that they had moved the vending machines as a trial. However the restrictive practice of locking the dining room doors denied people access to this space. People were restricted from accessing areas of their homes without appropriate consideration or reason.

Staff we spoke with gave us a variety of different explanations as to why the dining room was locked, including "we have always done it" and "to stop people taking the cutlery". We requested that the registered manager rethink this practice as it was not in keeping with person centred care.

Another person told us that it was their belief that hot drinks were "only allowed them at 11, 2 and 7 [times of day] but got a hot drink with breakfast and tea", they told us the reason for this was "that everything was locked away and you had to wait for staff". We spoke with the registered manager, the clinical manager and the clinical co-ordinators about this and they stated that drinks were available and people could access kitchen areas as needed. They agreed that this arrangement needed to be clearly communicated to people living at the service.

There were meals available from the kitchen however when we spoke with people they were not aware of what food choices were available that day. Menu information was available outside the dining room. This was in very small type and we found it difficult to read and to understand what menu choices were available that day. We saw that some people had special dietary needs and these were accommodated. The care records we reviewed included a discussion with people around what their food likes and dislikes were. In discussion with the staff they told us a number of personal preferences that people living in the service had. We saw that written records were not updated with this information. As a result the majority of information was shared verbally by staff and not written in a care plan or instructions within the kitchen. Without clear written instructions staff knowledge could be lost and inconsistent practice develop.

We reviewed care records and saw that the same actions as to meeting individual needs were recorded in different people's care records. As such individual person centred care was not planned and recorded with generic terms being used. We found that the care plans were not specific to people's personal needs and did

not take account of their personal preferences or views. We looked at the planning which was in place to promote peoples independence and to promote their development of life skills to move out of the service and into the community. We found that there was no planning that included the promotion of independence skills. One care record showed there was an activity interest checklist but this had not been updated for over a year. The person had records which showed what they had done for activities. This was repetitive and showed the person was undertaking the same activities none of which were related to the development of independence skills. This pattern was repeated in all the records we viewed. Additionally the activity records held by the occupational therapy team showed that the same people undertook the same activities. There was a programme in place that was not developed from individual needs and preferences to assist them in developing appropriate skills.

The management team and occupational therapy team explained that a new occupational therapist was to start working at the service and the decision had been taken to review all the therapy arrangements. This review had included the development of a new therapy room. There was a need for better communication regarding the use of this room as two people told us they thought this room was locked at 11pm The management team were clear that this was not the case and the room and its activities were available 24 hours a day.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not make sure people using the service received care or treatment that is personalised specifically or promoted their independence skills.

People told us they were aware of how to make a complaint and were confident they could express any concerns. One person told us that if they had any concerns they went straight to the registered manager and it was dealt with immediately. People, or their representatives, were provided with the verbal and written information they needed about what do, and who they could speak with, if they had a complaint.

We were informed that the service did not have any complaints which had been logged and investigated. When we reviewed the surveys and spoke to staff there were a number of minor concerns that according to the services policy should have been logged and appropriately dealt with.

It is recommended that the service deals with informal complaints in accordance with the services own policy.

There was a range of activities available within the service that people told us they enjoyed. People could freely choose to join in with communal activities if they wanted to. People who preferred to keep their own company, or that were confined to their own room because of their complex nursing care needs were protected from social isolation because staff made a conscientious effort to engage with them individually.

Requires Improvement

Is the service well-led?

Our findings

People spoken with demonstrated that they knew the registered manager, the clinical manager and the clinical coordinators well. They told us that they saw the registered manager and her senior team often and felt comfortable speaking with them. People who lived in the service told us they felt confident that they could go to the registered manager or to any member of the staff and they would be listened to and their views acted on. Staff spoken with felt confident that they could approach the registered manager and that they would be listened too.

The culture of the service was not based on the personal centred needs of the people who lived in the service but was task orientated. This could be seen by the routines in place in the service which were not flexible to meet people's needs, the views of some people that there was restrictions in place, care that did not meet people's needs and care that was not appropriately planned.

A registered manager was in place on the date of the inspection. We found that notifications of suspected abuse which should have been submitted to the Care Quality Commission (CQC) had not been. However the registered manager had reported allegations of abuse directly to the local authority safeguarding team. The systems in place were not sufficient to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included meeting medical needs, providing person centred care, recognising risk, care and welfare of people and appropriate training and development for staff.

The registered manager told us about audits that the service undertook to ensure people received quality care. These included regular checks on the environment and health and safety. We saw that the medicines checks had commenced and identified issues. However there was no monitoring of the audits and its findings in order to make sure that appropriate action was taken and improvements made.

We found that this was a common theme with audits on care plan contents, risk assessments and people's physical health records. Care plan audits had taken place and the registered manager acknowledged that care records did not reflect people's personal needs and preferences. We asked to see a plan of when the care plans would all be updated by and what support or resources the registered manager and staff would receive in order to progress improvements. There was no plan available and the registered manager was unable to state when all the people's needs that lived in the service would be re-assessed and appropriate plans put into place. We found several instances of care which placed people at risk. These issues could have been identified through a formal system to assess and monitor the quality of care if one had been in place.

Where audits had taken place they concentrated on whether the correct pieces of paper were in use and not if the contents of the completed records were of quality. As a result quality improvements were not discovered. Where issues were highlighted plans were not in place to monitor and improve the quality.

There were questionnaires available to people living in the service. These were also available for staff. The result of these had not been fully analysed and any identified actions not taken. Although meetings took

place for people who lived in the service and also separate team meetings for staff these showed that the same people regularly attended. The manager confirmed that the minutes of meetings were circulated. As such people living in the service and staff would not always be aware of the decisions taken at these meetings.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements to assess and improve the quality of the service provided.

The registered provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities with the exception of when safeguarding referrals were made to the Local Authority. The registered manager apologised for this oversight and stated that a notification for any safeguarding would be made in the future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider did not make sure people using the service received care or treatment that is personalised specifically or promoted their independence skills

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not made sure that care and treatment was provided in a safe way to people in their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have suitable arrangements to assess and improve the quality of the service provided

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 did not have sufficient arrangements in place to ensure that that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service.