Maple Health UK Limited

Maple Lodge

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Maple Lodge is a residential care home that provides personal care and support for up to five people who have a learning disability and/or autistic spectrum disorder. On the day of our inspection there were five people living at the service.

There was a 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 manager is registered for this service and one other local care service and is also one of the organisation's directors.

This inspection took place on the 9 May 2017 and was unannounced.

Prior to our inspection we received information of concern regarding incidents of alleged abuse against people who used the service. Despite a previous, recent reminder to the registered manager of the need to do so, we found they had on three occasions in the last four months failed to notify the Care Quality Commission (CQC) as they are required by law to do so of alleged safeguarding incidents of abuse towards people who used the service. This included incidents investigated by the police.

Staff had been provided with training in Safeguarding Adults from abuse. However, policies which guided staff in how to report poor practice and safeguard people from the risk of abuse had not been regularly reviewed. These policies contained out of date information and did not provide staff with up to date, relevant guidance in line with local safeguarding protocols and current regulatory requirements.

We found shortfalls in the proper and safe management of people's medicines. Controlled drugs were not held safely and there was a lack of audit trail which meant it was not possible to carry out audits. There was a lack of robust and effective audits which would have identified the shortfalls that we found at this inspection to enable the provider to respond to medication errors. The provider's medicines management policy, which provided staff with procedural guidance for ensuring the safe administration of people's medicines, did not provide the level of detail required in line with current legislation including National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes.

People were cared for safely by staff who had been recruited and employed after appropriate checks had been completed. People's needs were met by sufficient numbers of staff. Staff were provided with training relevant to their roles and responsibilities. People were not always treated with respect. Whilst most staff demonstrated caring attitudes to people who used the service, the culture and practices had been undermined by some.

The requirements of the Mental Capacity Act 2005 were not being met. Decisions were being made on behalf of people without the correct process having been followed to determine this was appropriate. Staff were

making decisions on behalf of people without appropriate assessments to support decision making which put people at risk of not having their human rights upheld.

People's needs had been assessed and care and support plans outlined their preferences and how they should be supported. People were supported to access the community and follow their interests. There were systems in place to support people to maintain their health and wellbeing. People had balanced nutritious food provided. People's weights were regularly monitored and recorded. However, we noted that some weights recorded showed significant losses and gains from week to week with no information recorded as to any actions taken in response. People were supported to access health care including learning disability and epilepsy specialists.

There were systems in place to manage complaints and review incidents, audit performance as well as monitoring the quality and safety of the service. However, these were not effective at identifying the shortfalls that we found at this inspection. This put people at potential risk of harm.

During this inspection we identified 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 this 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 safe.

Staff were provided with training in safeguarding adults from abuse. However, whistle-blowing policies which guided staff in how to report poor practice had not been regularly reviewed. Safeguarding policies contained out of date information and did not provide staff with up to date, relevant guidance in line with local safeguarding protocols and current regulatory requirements.

There were shortfalls in the safe storage and proper and safe management of people's medicines.

People were cared for safely by staff who had been recruited and employed after appropriate checks had been completed. People's needs were met by sufficient numbers of staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were provided with training relevant to their roles and responsibilities.

The requirements of the Mental Capacity Act 2005 were not being met. Decisions were being made on behalf of people without the correct process having been followed to determine this was appropriate.

There were systems in place to support people to maintain their health and wellbeing. People had balanced nutritious food provided. People were supported to access health care including learning disability specialists.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with respect.

Whilst most staff demonstrated caring attitudes to people who

used the service, the culture and practices had been undermined by some.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care and support plans outlined their preferences and how they should be supported.

People were supported to access the community and follow their interests.

There was a system in place to manage complaints but did not always evidence the outcome of any investigation with actions taken in response.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was inadequate oversight at registered manager and provider level.

There were systems in place to manage complaints and review incidents, audit performance as well as monitoring the quality and safety of the service. However, these were not effective at identifying the shortfalls that we found at this inspection. This put people at potential risk of harm.

Maple Lodge

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 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 comprehensive inspection took place on the 9 May 2017 and was unannounced.

The inspection was carried out by two inspectors.

Prior to our inspection, we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We also reviewed safeguarding alerts and information received from a local authority.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

People using the service had complex needs with limited verbal communication skills which meant that they could not readily tell us about their experiences of using the service. However, during our inspection we observed the care and support provided to people and interactions between people and the staff who supported them.

We spoke with the registered manager, team leader and four care staff. We reviewed two people's care records, three staff recruitment files including a record of training provided to staff, staff communication processes in place, assessed the management of people's medicines and reviewed quality and safety audits, risk assessments and policies.

Following our visit to the service we spoke with two relatives of people who used the service and stakeholders including local authority commissioners.

Requires Improvement

Is the service safe?

Our findings

We found shortfalls in the proper and safe management of people's medicines. We carried out an audit of stock. One person's stock of medicines did not balance with the MAR records as we found items of Epilim missing and unaccounted for. This is a medicine used to for the control and treatment of epilepsy. Whilst the team leader searched for these medicines a carrier bag containing four containers of a controlled drug were found in a desk drawer. All controlled drugs stored in the home must by law be stored in a controlled drugs secure cabinet. The team leader told us they did not know why these medicines were stored in this way and suggested this may be because there was not enough room in the medicines cabinet and suggested they may be awaiting return to the supplying pharmacy. However, there were no records to evidence this.

We saw that there were ineffective systems in place to manage and monitor where people had been prescribed medicines to be administered on an 'as and when required' basis known as (PRN). For example, we found for one person where paracetamol a pain relieving medicine which had been purchased as a homely remedy, there was no PRN medication profile in place. This would provide guidance for staff as to how and when this medication should be administered. There was also no record of this medicine on the medicines administration record (MAR).

Records as required by law had not been maintained to evidence an audit trail in the medicines discharged from the service. For example, where two people currently on holiday who had medicines removed from the service, there were no records produced to evidence the stock including amounts removed.

We saw that two people had been described in their care and support plans as receiving their medicines covertly. However, following discussion with the registered manager and team leader it was evident they lacked understanding as to what constituted 'covert administration'. Covert administration of medicines is when medicines are given in a disguised form without the knowledge or consent of the person receiving them. Any decision to give medicines by covert administration must only be agreed following a best interests meeting and recording any decision made by those qualified to make those decisions.

We reviewed the provider's medicines management policy which provided staff with procedural guidance for ensuring the safe administration of people's medicines. We found this policy was brief in detail and failed to provide guidance to the level of detail required in line with current legislation including the National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes. For example there was no guidance in relation to the management and administration of covert medicines, homely remedies and only brief information in relation to social leave which did not reflect the current practice we observed. This meant that staff responsible for administering people's medicines did not have the relevant guidance to mitigate the risks to people's health, welfare and safety.

There was a lack of robust and effective audits which would have identified the shortfalls that we found at this inspection to enable the provider to respond to medication errors. Weekly medication audits of stock were carried out by the same member of senior support staff who also ordered, received and disposed of medicines. The registered manager and provider audits did not evidence any robust checks on medicines

management, checks of stock including controlled drugs against records.

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

Staff were provided with training in Safeguarding Adults from abuse. However, policies which guided staff in how to report poor practice and safeguard people from the risk of abuse had not been regularly reviewed. These policies contained out of date information and did not provide staff with up to date, relevant guidance in line with local safeguarding protocols and current regulatory requirements.

Prior to our inspection we received information of concern regarding incidents of alleged abuse against people who used the service. By law services are required to inform the Care Quality Commission (CQC) of any safeguarding incidents. However, despite a previous, recent reminder to the registered manager of the need to do so, we found they had on three occasions in the last four months failed to notify the CQC) of alleged safeguarding incidents of abuse towards people who used the service. This included incidents investigated by the police. We discussed this with the registered manager during our inspection visit.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Risk assessments had been developed to identify any potential risks to people and implement control measures to reduce these as far as possible. Risk assessments we reviewed were individualised, detailed and provided staff with steps they should take to mitigate the risks to people's health, welfare and safety. For example, risks associated with accessing the community, using public transport, eating and drinking and environmental risks. Where risks had been identified in relation to people who may become distressed, anxious and agitated, possible triggers had been identified with proactive strategies in place to guide staff in how to manage behaviours that may challenge in a safe manner.

Where people had been diagnosed with Epilepsy, care plans described the type of Epilepsy, potential triggers and management plans to guide staff as to what action they should take in the event of the person experiencing a seizure. This meant that staff had been provided with guidance as to the steps they should take to safeguard people from the potential risk of harm to their health, welfare and safety.

Everyone who lived at the service had been funded by commissioners of care, with one to one staffing as their needs determined this level of support was required. Staff told us that people received their one to one support but that there were staffing vacancies which meant staff worked extra shifts or agency staff were employed to cover staff shortages. Staff also told us that the agency staff employed were regular workers to ensure consistency of care was provided to people. One relative told us, "There has been a high turnover of staff but we have never been concerned or had it brought to our attention that there is not enough staff for [relative's] one to one support." Another relative said, "We are confident that the agency staff who work at the service are competent and know [relative's] needs well. There always appears to be enough staff around." However, we noted on the day of inspection one person was supposed to be going to college and were unable to attend as they required two to one staff support to access the community and there was insufficient staff available to facilitate this.

The provider had established and operated recruitment procedures effectively to ensure that staff employed were assessed as safe to work with people who may be vulnerable and that they had the skills necessary for the work they were employed to perform. Staff recruitment records we reviewed showed us that the

provider had carried out a number of checks on staff before they were employed to make sure staff recruited were of good character. This included enhanced disclosure and barring checks (DBS); checking their identification, health, conduct during previous employment and checks to make sure that they were safe to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

The majority of staff had been provided with training appropriate for the roles they were employed to perform. Training provided included understanding and supporting people with autism, positive proactive intervention which was provided by one of the directors, epilepsy awareness from clinical specialists and core training such as infection control and health and safety, including risk management. Staff told us that they were provided with equality & diversity, dignity & respect training. Newly employed staff, told us as part of their induction they were working towards the nationally recognised Care Certificate, which all staff were required to complete commencing employment.

Staff told us they received support through one to one supervision meetings with their line manager. One to one supervision meetings provided staff with the opportunity to identify and plan for their training and development needs as well as the opportunity for the manager to review work performance. We received mixed views from staff as to the regularity of these meetings. However, we noted that staff were provided with regular, monthly staff meetings. A review of staff meeting minutes showed us that these meetings provided opportunities for staff to raise issues of concern and for discussions regarding team working performance. We noted that following recent safeguarding incidents staff were reminded of the need for personal and professional boundaries and to improve the manner in which they communicated with people who used the service.

There were systems in place to ensure important information about people's health, welfare and safety needs were shared with the staff team. This included daily handover meetings. We saw from a review of handover records that staff had been supported with guidance to enable them to meet people's needs and evidence when tasks had been completed, which also provided an audit trail for management reference.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us they had received training in safe physical intervention and they said this gave them the skills to work with the people safely and appropriately who lived in the service. Staff confirmed that they used 'holds' on people as described in their support plans and only as a last resort. They then completed records which would describe the reasons why this was necessary. However we found that these records had not always been completed following incidents.

Where people lacked capacity to consent to their care and treatment, staff did not always act in accordance with the Mental Capacity Act 2005 and associated code of practice. Capacity assessments had been carried out in relation to areas such as finances, communication, daily living, medicines and activities. However, the correct process had not always been followed to seek authorisation from those qualified to do so when making decisions in people's best interests. Staff did not always recognise potential restrictions to people's freedom of movement and these were not always appropriately managed. We observed one person's

freedom of movement around the home was physically restricted by staff during meal times. This they told us was to prevent the person from going into the kitchen when other people were eating their meals. To prevent this person from leaving the lounge, one member of staff sat on a chair in the doorway blocking the person from leaving the room. We also noted another member of staff place their hands on the person to move them around and back into the room. There was no evidence of any best interest assessment having been carried out in relation to this activity, no involvement to agree this plan of care from the person, the person's family or relevant professionals. Staff confirmed that no applications to authorise this activity in this person's best interests had been submitted to the local safeguarding authority to ensure that a best interest assessment had been carried out by those qualified to do so. This meant that staff were making decisions on behalf of this person without appropriate assessments to support this decision and thus put people at risk of not having their human rights upheld

This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dietary needs had been identified as part of their plan of care. We saw that individuals were supported to improve their daily living skills and encouraged to help with shopping and the preparation of their meals. Staff told us that people's individual's needs were assessed in the planning of weekly menus. We reviewed the weekly menu planner and noted that the same meals were planned for each person daily. We also noted that supper recorded for each person specifically stated; 'hot drink with two biscuits'. Following discussions with staff we were unable to determine why only two biscuits were specified on the weekly menu plan. People's weights were regularly monitored and recorded. However, we noted that some weights recorded showed significant losses and gains from week to week with no information recorded as to any actions taken in response. We discussed our observations with the team leader as we had observed one person with low weight, who was constantly on the move and who may require additional calorific intake.

People were supported to access healthcare as required. Care and support plans included details of planning to support people to maintain their health and wellbeing. The service had good links with other healthcare professionals and specialists such as; intensive support learning disability professionals, psychiatrists, GPs and dentists. People were supported to attend annual health checks with their GP when required. Staff were observant of people's changing health conditions and sought prompt medical advice for them. Hospital passports had been developed to provide clinical staff with detailed information about each person should there be a need for them to be admitted to hospital. Both relative's we spoke with told us that staff picked up on changes in people's health and wellbeing in a timely manner. Any changes were communicated to people's relative and they told us they were kept fully informed.

Where psychiatric support was required or where individuals were diagnosed with epilepsy, people had clear support plans to guide staff in how to respond and monitor people to keep them safe. There was evidence of when people had been supported to access advice and support from health care and mental health professionals with evidence of regular reviews and support from staff to attend health care appointments. Daily notes recorded the outcome of any recommended treatment or when follow up was required.

Requires Improvement

Is the service caring?

Our findings

Whilst most staff demonstrated caring attitudes to people who used the service, the culture and practices had been undermined by some. We spent time with people in the communal areas observing care and interactions between staff and people who used the service. We observed there to be a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and picked up on non-verbal communication, checked that they had understood what was being expressed and provided reassurance when required. However, we were not assured that people were always treated with dignity and respect. Recent safeguarding incidents investigated with outcomes that demonstrated a lack of consistent caring and compassionate care for people. We also noted from a review of staff meeting minutes that the manager had recently challenged the behaviour of some staff and recorded; 'It has come to my attention that some staff are still being abrupt with service users at meal times, especially. Please take on board your communication with service user's. The abruptness needs to stop.'

Care plans included guidance for staff on how to approach people with care and compassion and contained specific guidance for staff in how best to deliver care in a respectful and dignified manner. These were regularly reviewed, to ensure staff understood when people may need more support and attention. Staff had been provided with guidance in recognising triggers and pro-active strategies including distraction techniques to ease a person's agitation and distress.

We saw that people with limited verbal communication skills were supported to express their needs, wishes and preferences through a variety of communication tools such as; objects of reference and the 'Picture Exchange Communication System' (PECS). This enabled people with to communicate using objects, pictures and symbols.

People's bedrooms were personalised and contained photographs, art work and personal items which reflected people's individuality and personalities. Staff respected people's private space, for example waiting for a response from people before entering their room.

Relatives made positive comments about the care their relatives received and the impact this had on their lives. One relative said, "We are pleased with the progress [relative] has made. We have seen a positive change in their behaviour and they are happy there." Another told us, "I have not had any concern about the behaviour of staff they have always demonstrated good care in our presence anyway. I have always found the staff friendly, kind and I would know if [relative] was unhappy there and I can see that they are happy and live a fulfilled life."

People and their relatives told us they were supported and encouraged by staff to maintain links with their family, friends and the local community. One relative told us, "There are no restrictions. We visit whenever we want and they always make you welcome. They also email me regularly to update me with things I need to know."

Good

Is the service responsive?

Our findings

People's support plans were detailed, person centred and reflected their needs and where appropriate a pictorial support plan was in place to enable them to understand their plan of care more effectively. Support plans included information on maintaining people's health and wellbeing, likes and dislikes and their daily routines. Support plans set out what people's needs were and how these should be met. This gave staff specific information about people's care and treatment needs including support required to support people to maximise their independence.

Staff told us they had easy access to care plans and were involved in their review to ensure up to date information was provided to reflect people's changing needs. Staff knew people well including their preferences for care and their personal histories. Staff told us that they supported people to maintain their independence as much as possible and helped them to develop life skills such as personal care, cooking and housekeeping skills.

Support plans we reviewed reflected the current care and support needs of each person with up to date and relevant information about their healthcare, personal care support, likes and dislikes and aspirations. Relatives told us they were invited to care reviews but were unclear as to how often these should be organised. Local authority reviews for people with their allocated social worker were for some people infrequent which meant that there was a lack of monitoring from those who commissioned people's care.

Where people presented with distressed behaviours which put them and others at risk, behavioural management plans had been produced following advice and guidance from specialists such as learning disability nurses and intensive support teams. Support plans contained guidance for staff as to potential triggers and steps they should take to support people and action for staff to take if physical de-escalation was required in a safe and dignified manner.

Support plans were all regularly reviewed and were up to date to reflect people's current care and support needs. Daily records were completed by staff and contained information about what people had been supported with, what they done and what they had eaten. There was also a communication book and handovers between shifts which enabled staff to have the up to date information they needed to respond to individuals changing needs and information about the daily running of the service.

People were supported to take part in a range of activities and personal interests outside of the home. One relative told us, "My [relative] gets out and about a lot. They get the chance to mix with other people in the community and get to attend social clubs where the meet friends and people they are familiar with. They love woodwork and get to do this regularly which is good for them. [Relative] has come on leaps and bounds since they went to live at Maple Lodge." Another relative told us, "We see [relative] regularly and can see they are very happy there. They have just come back from holiday which they thoroughly enjoyed."

We observed during our visit that people were supported out into the community shopping, swimming and two people were away on holiday. Whilst in the home engaged in little activity other than watching TV. Some

people attended college where they learnt life skills. Each person had a full programme of activities, planned according to individual's needs and preferences. This was displayed in an easy read pictorial format and available for people to refer to. People attended local weekly social clubs, enjoyed trips to theme parks, music sessions and sports activities.

The provider had a system in place to respond to suggestions, concerns and complaints. This was freely accessible and in a pictorial format. Relatives told us that when they had raised any concerns these had been responded to promptly with outcomes to their satisfaction. Relative's we spoke with told us they had not had any reasons to submit any formal complaints and were satisfied that when they had any queries or minor concerns these had been dealt with promptly and appropriately.

Where people could not verbally express their views communication tools were used such as referral to objects of reference and pictorial prompts to enable people to express their wants, needs and feelings.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who was managing both this service and one other of the provider's services locally. The registered manager was also one of the organisation's directors.

There were ineffective systems and process in place to enable the provider to identify where the quality and the safety of the service was being compromised. We saw from a review of the provider and registered manager's quality and safety audits that these were brief in detail. For example, where the provider said they had spoken with staff as to how they promoted people's independence, there was no record of how many staff they spoke with, who they spoke to and what their responses were. We also found that there was a lack of effective, provider and registered manager governance which would have identified the shortfalls we found at this inspection. For example, a lack of effective oversight in the auditing of medicines management which would identify errors, the notification of incidents such as safeguarding allegations of abuse and DoLS notifications. Further work was required to ensure the provider's policies and procedural guidance was regularly reviewed and updated to reflect current good practice and regulatory requirements.

The failure to develop effective systems for management and governance of the service had left people at the potential risk of harm.

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

Most of the staff we spoke with were positive about the support they received from the team leader. Staff were clear about their roles and responsibilities as well as the organisational structure of the service and who they would go to for support if needed. Staff and relatives told us that the team leader was the main point of contact and had responsibility for managing the service on a day to day basis with occasional oversight from the registered manager. Everyone we spoke with expressed their confidence in the team leader. Relatives told us, "She is great, reliable and approachable." And "We are kept fully informed of any changes, receive regular emails with updates and couldn't be happier with the care [relative] receives." Staff told us, "The team leader is well organised and she does a great job. Anything you are worried about she is the go to person." And "The team leader is very hands on and supportive."

There were clear communication systems in place such as regular staff meetings, staff daily handover meetings from one shift to another and communication books. The provider had systems in place to support staff and monitor performance such as one to one supervision and annual, appraisal meetings where staff could discuss their training and development needs. Staff told us they were actively encouraged to question practice and make suggestions for improvements and their ideas were listened to.

Staff told us that there were clear arrangements in place in the event of any emergency. Staff performance was monitored as the team leader carried out competency observations of staff practice. Where shortfalls were found, additional training and support was provided.

The views of people, their relatives and staff were surveyed through annual satisfaction surveys. The response from these helped the provider to see where improvement of the service was needed. However, there was limited evidence of any learning from this feedback or plans in place for the continuous improvement of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC without delay regarding allegations of abuse in relation to a service user; of alleged safeguarding incidents including those investigated by the police. The provider failed to notify CQC of DoLS applications made to the local authority to request authorisation to restrict the freedom of people's movement. .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to consent to their care and treatment, staff and the provider did not always act in accordance with the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to manage and store controlled drugs as required by law. The provider's medicines policy failed to provide guidance to the level of detail required in line with current legislation and National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems and process in place to enable the provider to identify where the quality and the safety of the service was being compromised. There was a lack of provider and registered manager governance and oversight in the auditing of medicines, which would have identified the shortfalls that we found at this inspection.