Quest Haven Limited

The Ranch

Inspection report

Well Path
Well Lane, Horsell
Woking
Surrey
GU21 4PJ

Tel: 01483855952
Website: www.quest-haven.com

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

The Ranch is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Ranch provides residential care for three people with learning disabilities. At the time of our inspection there were three people living at the service who had a range of needs such mental health diagnoses and learning disabilities.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen

The inspection took place on 11 January 2019 and was announced.

The service had a registered manager in post. 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.

Risks to people were not appropriately recorded. There was no monitoring or analysis of accidents and incidents that had taken place to identify trends and reduce further risk. Care plans were not person-centred and did not include any detail around people's end of life wishes or health diagnosis. Safeguarding procedures were not always followed and appropriate notifications were not made to the CQC and the local authority. People's rights under the Mental Capacity Act 2005 (MCA) were not protected. The service did not follow the principles of the MCA and correct legal authorisation had not been sought to deprive people of their liberty.

Medicines had not always been stored at an appropriate temperature and people's medicine profile did not include any information around allergies. There were no gaps in Medicine Administration Records (MARS) and protocols were in place for 'as and when' medication.

There was not a sufficient number of staff to meet people's needs. Some staff did not receive adequate breaks between shifts. Recruitment practices were not robust. Staff were not up to date with their mandatory training. Staff told us that they were not receiving regular supervision and appraisals.

The service did not have robust quality assurance systems in place. Internal audits that had taken place had not identified the issues that we had during our inspection. The service had not notified the Commission of all reportable incidents. This included incidents where people living at the service had unexplained bruising.

People and their relatives were involved in the review of their care. However, this was not recorded in

people's care files. People were treated with kindness, respect and dignity. People and relatives told us they would feel comfortable raising a complaint if they needed to. People had a choice of foods, and their weight was monitored regularly. The premises was suitable to meet people's needs effectively. People were able to personalise their rooms to suit their taste.

Staff and relatives felt that the registered manager and deputy manager were approachable. There was partnership working with a local day centre. Plans were in place to improve the service. However, the deputy manager felt they needed more staff to allow the time required to be able to implement these changes. We did not observe any pre-assessments as people at the service had been living there for many years.

People were being cared for by staff who were aware of and carried out safe infection control processes. People had access to a wide range of healthcare professionals, such as GPs, dentists and opticians. People were encouraged to take control of their appointments.

During this inspection we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version 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.

Staff were aware of safeguarding policies. However, the service had not informed the relevant authorities of safeguarding incidents that had occurred.

Risks assessments were not appropriately recorded and did not contain up to date information. However, staff knew people and their needs.

Practices around medicine storage and administration were not always safe. However, there were no gaps in Medicine Administration Records (MARs).

There were not a sufficient number of staff to meet people's ongoing needs. Staff had not been recruited safely.

People were cared for by staff who mostly adhered to infection control practices. However, we found that people had access to a cupboard containing substances that were hazardous to health.

There was no monitoring or analysis of accidents and incidents to identify trends and prevent any further occurrences.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not protected in line with the principles of the Mental Capacity Act 2005.

Staff were not up to date with their mandatory training, and did not receive regular supervision.

People were supported to maintain a healthy diet.

Referrals to healthcare professionals were made were required. People were encouraged to take responsibility in their appointments.

Relatives and staff felt that communication within the service was effective. Relatives said that they were kept up to date with information.

The design of the premises was adequate to meet people's needs.

Is the service caring?

Good

The service was caring.

People were very complimentary about the staff, and said that they were treated with kindness and respect.

People were encouraged to be independent where possible. People's privacy was also respected.

Staff and relatives informed us that people were involved in their care plan reviews. However, this had not been recorded in people's care files.

Is the service responsive?

Requires Improvement

The service on the whole responsive.

Care plans were disorganised and not person-centred. They did not include details around people's needs and diagnoses, such as mental health and communication.

People and relatives told us that they had not needed to complain, but would feel comfortable doing so if needed.

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

Is the service well-led?

Inadequate

The service was not well led.

Although people and staff said the registered manager was approachable, there was a lack of management oversight in the service.

There was no robust quality assurance process in place to check and improve the quality of the service. Issues that had been identified during internal quality assurance visits had not been followed up.

Record keeping around service users and the running of the service was disorganised.

The registered manager had not made the Commission aware of any notifiable incidents which put people at risk.

There were plans in place to improve the service, but a lack of staff meant that it was unlikely that they could be implemented.

The Ranch

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 11 January 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because the location was a small care home for adults who are often out during the day and we needed to be sure they would be in. The inspection team consisted of two inspectors.

We used information the provider sent us in 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 also checked if the service had made us aware of any notifiable events.

During the inspection we spoke with three people who lived at the service and one member of staff. We carried out general observations throughout the day and referred to a number of records. These included three care plans, records around medicine management and policies around the running of the service.

Following the inspection, we asked the registered manager to provide us with information we were not able to obtain on the day of the inspection. This included three recruitment files, quality auditing reports and evidence of mental capacity assessments. We also spoke to two relatives and one staff member over the phone.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt the service was safe. One person told us, "I feel safe here most the time. Sometimes I get told to go to my bedroom when [another resident] is upset to stay safe." Another person said, "I would not want to move from this house." A relative told us, "I think [my family member] is pretty safe and well looked after there. They have a locked door policy." Another relative said, "I feel they're safe because they know what their difficulties are and have a good understanding of them. There have been a couple of incidents there involving [my family member] but they would have happened regardless of where they are. The staff dealt with the incidents appropriately." However, we found evidence that people were not always cared for in a safe way.

Risks to people were not always being recorded appropriately. Risk assessments contained information that was no longer accurate and did not reflect people's current needs. A risk assessment for one person dated 2018 stated, '[The person] is reported to be at risk of absconding' and 'Staff to ensure that the front door is locked at all times when they are with [the person] in the house.' However, on the day of our inspection, the person was going in to the community independently. We asked the deputy manager who informed us "[The person] can go out on her own. The information is really out of date."

Another person's risk assessment also stated that they were not allowed to leave the house by themselves. However, we were made aware of an incident where the person had been out independently and had fallen. The deputy manager confirmed this person was also able to leave the service independently. Although current staff members knew this, it meant that new staff members would not be aware of the correct information and therefore may not provide the correct care to people.

Action had not always been taken to reduce the risk of harm to people. One person's risk assessment around a health condition stated they should not have any furniture with sharp corners in their room. However, when the person showed us their room we observed steps had not been taken to put equipment on furniture to soften the edges. The deputy manager informed us that the person had not suffered a seizure for years, but this meant that the service was not prepared in managing the risk of it happening in the future. The cupboard where hazardous cleaning materials were kept was left open and was accessible to people during the inspection. This meant that people were at risk of harm. Following the inspection, the Registered Manager has informed us that they will put a lock on this cupboard.

Steps had not always been taken to ensure that people would be safe in the event of an emergency. Personal emergency evacuation plans had not been completed for people. These documents state what individual support people required to evacuate the building in the event of an emergency. Without these staff would not know what to do in the event of an emergency or know what support to give people. There was no missing person profile for one person who regularly travelled independently. This meant if the person did not return as expected, staff would not have details of the person to pass onto the police or other relevant agencies who would be involved in searching for them. However, fire safety precautions were taken. People took part in weekly fire drills to ensure they were prepared in the event of a real fire, and learning given to those who required it following these drills. Fire extinguishers were checked monthly.

The service completed accident and incident forms but did not analyse the information to learn lessons and improve where things had gone wrong. Accidents or incidents that had occurred were stored in a central file. However, there was no evidence that the provider and staff had used these incidents as a learning event to prevent any future occurrence. We found incidents that had occurred between people that we were not made aware of. The service also did not monitor any trends of accidents and incidents that occurred. The impact of this was that lessons were not learned to prevent any further incidents occurring again in the future. This placed people at risk of avoidable harm.

Medicine storage and administration was not always safe. Medicines had not always been stored at an appropriate temperature. There was evidence that staff checked and recorded the temperature of the medicines cabinet each day. However, these records demonstrated that on some days the temperature of the medicines cabinet was above that specified in national guidelines. This meant that the integrity of the medicine could be compromised. The Registered manager informed us that they are currently looking in to how to rectify this issue. Each person had a medicines profile in place which contained a recent photograph and details of the medicines they took, including medicines prescribed as required (PRN). However, people's medicines profiles did not record any details around their allergies. The Registered Manager informed us that these would be added immediately. Medicines administration records (MARs) were consistently completed and contained no gaps or errors. A relative told us, "[My family member] has always received them as far as I'm aware." One person visited a community mental health professional every three weeks to receive a controlled medication, which was recorded in the person's records.

Failure to provide safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they felt there were enough staff to meet their needs. One person told us, "Yes there is enough staff, and they are all nice as well." A relative said, "I do feel there's enough staff there." Another relative said, "I think it's pretty well staffed."

However, despite people's positive feedback around this, there was not always a sufficient number of staff to be able to continuously meet people's needs. A staff member told us, "I think at the moment they need more staff. I know they're recruiting though. It would be better to have more staff just so people there have more choice. One can go out and one can stay at home if they want to." The deputy manager told us, "At the weekends it would be better to have two staff members as [one person] can become anxious and not want to go out and that can affect the others as then sometimes they can't go out. I'm a lone carer six times a week, as well as the driver, paying the wages, covering sickness."

Rotas showed there was one member of staff working during the day, and another staff member for the night shift. However, this did not allow flexibility if one person did not want to go out during the day but other people did. For example, one person did not want to take part in a planned outing. Due to there being only one staff member this meant the person was taken to the provider's other service while the staff member took other people on the planned outing. This did not allow the person to have the choice to remain at their home.

Staffing rotas demonstrated that staff members were working long hours. For example, on one occasion one member of staff had worked a night shift at the provider's other service, then completed two hours at The Ranch after a four hour rest, which was followed by another night shift at the provider's other service. On another occasion, another member of staff had completed a seven hour day shift at the provider's other service, and then completed a night shift at The Ranch. This meant that staff were not receiving adequate breaks in between shifts at work. This could impact the quality of care that people received.

The failure to provide a sufficient number of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Safe recruitment practice was not always followed. We asked the registered manager to send us copies of three recruitment records for the staff members that were most recently employed by the service. We only received one full recruitment file including their Disclosure Barring Screening certificate which confirmed that they were safe to work with vulnerable people. However, it did not include all the required information to ensure that the staff member had been recruited safely. This included references from previous employment and photographic identity of the staff member. The deputy manager confirmed, "Staff do not have a picture ID."

The failure to safely recruit staff was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Safeguarding procedures were not followed and appropriately reported. Accident and incident forms related to incidents that had not been reported to us or the local authority in line with statutory safeguarding procedures. For example, one person had multiple unexplained bruises and injuries noticed on different dates. This left people at risk as concerns could not be appropriately investigated to ensure that people were safe from harm. Despite this staff said that they were aware of safeguarding policies and procedures and how to report any concerns. A staff member said, "Safeguarding is about protection for vulnerable people to make them free from abuse and neglect. If I saw something I would first make them comfortable and I would inform my line manager. I would also inform the safeguarding team if needed." The deputy manager told us, "It's about maintaining that they're safe in their home, in the environment and in the community. I'd speak to the boss first, then higher up or whistleblow if needed." Although staff knew how to report safeguarding concerns, they had not followed safeguarding procedures. After the inspection the provider told us staff would be given refresher training to address this.

The failure to appropriately report safeguarding concerns was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who were aware of and carried out safe infection control processes. A staff member said, "We always wear aprons and gloves for personal care. It's very important that we do." The deputy manager told us, "They should always wear gloves and aprons. They're kept in the office and toilet." Residents meetings focused on a different health and safety issue each time. For example, in one meeting, people were asked what they would do if they noticed a hazardous cleaning substance was left out. This was to ensure that people would be aware how to react, and if not, to educate them on what they should do.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. 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 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were not always acting in line with the principles of the MCA. A staff member told us, "If a person lacks capacity, we need to assume they have capacity to start with." However, the deputy manager told us, "I think we will be acting in line with it. The first time I was aware of it was three years ago. I definitely feel like I need more knowledge on it. I don't think if you asked, any members of staff would be able to answer it for you. It's not a mandatory course for us but it should be."

Decision specific mental capacity assessments were not completed. For example, one person was not able to leave the service unsupervised, but no mental capacity assessment had taken place around this. There was no evidence that best interest meetings and decisions had taken place. Furthermore, DoLS had inappropriately been applied for where restrictions to people had been put in place. The deputy manager told us DoLS authorisations were in place for two people but could not tell us why the applications had been submitted or which restrictions they related to. The deputy manager said, "I know [one person] had one but I'm not too clued up on it myself. I think it might be in relation to going out." No mental capacity assessment or best interest decision had been completed for this. This meant people were being unlawfully deprived of their liberty.

Failure to act in accordance with the provisions of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they felt staff were well trained. One relative said, "They seem to know what they're doing." Another relative told us "Generally yes I feel that they are well trained." The deputy manager told us, "I've been handed the training to organise, and it was in a state to start with but I've worked really hard on getting it where it needs to be." Another staff member said, "Training is brilliant, they always encourage us to do more."

Despite these comments, people were being cared for by staff who were not up to date with their mandatory training. Following the inspection, we received a copy of staff's training records. There were seven types of training that the provider considered mandatory for staff. Training records showed that no staff were up to date with this training. One member of staff had completed their online safeguarding adults training but had failed to pass the course. Another member of staff had not completed any of the mandatory training, whilst another was overdue with their refresher training on all of the mandatory subjects. In the remaining 19 areas

of additional training available, training was also out of date or not completed. This included topics that were relevant to staff's roles, such as behaviours that challenge, communication and autistic spectrum disorder training. This presented a risk of staff not being able to provide effective care to people. The training records did not show that staff had completed a lone working course as mentioned above by a staff member. This meant that accurate and up to date records around training were not kept by the provider.

Staff said that they did not receive regular supervision. One staff member told us, "We don't have supervision often unless we have something to talk about that's confidential. Then we have to request one." The deputy manager said, "Generally staff should have supervision quite frequently. I think we need to be hotter on that to be honest." We asked the registered manager to send us information in relation to the occurrence of staff supervisions and appraisals by 16 January 2019. However, this was not received. That meant that we are unable to establish that there was an effective supervision and appraisal process in place to monitor staff effectiveness.

The failure to effectively provide staff with relevant training, supervision and appraisals was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views around the food at the service were positive. People were involved in choosing the food they ate. One person said, ""We can choose the menu." A relative said, "I've seen some of the meals they have and they seem the kinds of meals you would have at home." The deputy manager said, "They choose what they want and we shop for it." Staff responded to people's dietary requests. The deputy manager told us people met as a group weekly with a member of staff to decide what they would like to see on the menu for the coming weeks. Monthly weight charts were completed which showed people's weight had been mostly consistent. Where people had put on surplus weight, action had been taken. The deputy manager told us, "We worked on portion control and that person is now a healthy size. We do weekly weigh-ins and make it fun." This meant that people were encouraged to maintain a healthy weight and diet.

People had access to health care professionals. One relative told us, "[My family member] always had access to health care professionals where needed." Another relative said, "[My family member] has regular GP, dentist and optician appointments." A staff member told us, "People always go to their appointments." People were encouraged to take control of their appointments. The deputy manager said, "[One person] goes to her community psychiatric nurse meeting alone but I stay in the waiting room. We go in to the consultation room with the others." We observed evidence of dentist, optician and GP involvement in people's care plans. One person also had regular visits from the district nurse to administer a controlled medicine.

The adaptation of the premises was suitable to meet people's needs effectively. People had their own bedrooms and bathrooms, and there was a garden people could access. It was made to feel homely for people living at the service. There were three photograph collages on walls around the service, showing recent outings and activities they had taken part in. The provider had installed a canopy outside the building so that one person who smoked could do so without getting wet.

There were effective communication processes in the service. A relative said, " I have no significant issues here. Whenever I've ever needed to contact them it's been responsive.". A staff member said, "If we had to communicate something to another staff member we would leave information in the communication book. We do a verbal handover too. It works well." The deputy manager told us, "We've introduced handwritten communication book since the last inspection as well as the verbal handover." The communication book contained basic information on what people had done throughout the day. Feedback received from a local day centre praised the service for providing clear communication on the people attending and if they had

had any recent changes.

We did not view any pre-admission assessments as people had been living at the service for many years and there had been no recent new admissions.

Good

Is the service caring?

Our findings

People and relatives told us they felt that staff were respectful and caring. One person told us "The staff are nice to me." A relative said, "They always give the opinion that they're kind and caring when we're there. You can see it's not just a job to them." Another relative told us, "I've seen them handle [my family member] when they have been upset and they've always responded in a calm and caring manner." The deputy manager told us, "We're like a happy family here."

People were treated with kindness and respect. We observed positive interactions between the deputy manager and the people who lived at the home. People and the deputy manager engaged in friendly conversation and told us they got on well with the deputy manager and other staff. People told us they liked the staff who supported them and enjoyed their company. People were supported to maintain relationships with their friends and families. People told us they invited their friends and families to the home and said staff supported them to visit friends and relatives. Two people told us they regularly visited their children. The deputy manager told us one person maintained regular contact with their family by phone. The person told us, "My father visited me at Christmas. My brother visits me here too."

People's privacy and dignity was respected by staff. One person told us, "They always make sure they knock." Another person said, "I just go in my room and shut the door." The deputy manager told us, "Staff knock on their doors when they go in their rooms." The deputy manager also explained one person would typically dress in clothing that showed their midriff. They told us, "It's fine to do when they're at home, but we remind them when they're going out in the community that they should cover up a bit more." This demonstrated that staff supported people to maintain their dignity when accessing the community independently.

People were supported to be independent where possible. One person told us, "I go to the local village to go shopping and have a coffee in a local café." A relative said, "They encourage them to be independent within the limits of their own safety. [My family member] does their own laundry." One staff member told us, "We always try to empower a person, like encouraging them to do things like washing up, cleaning, and laundry." The deputy manager supported people to make their lunch and allowed them to complete the tasks they were able to manage independently. One person had also completed their own laundry during our inspection. The staff member said, "We let them do whatever chores they are able to. Things like washing up, and some of the tasks when cooking dinner." This meant that people were encouraged to maintain the skills that they had and remain independent as long as possible.

People were involved with the planning of their care and support. A relative said, "We've been to quite a few of the reviews there and they've always included my family member." Another relative told us, "They try to accommodate [my family member] in the reviews as best as they can as sometimes they can become upset in them. They're annual meetings." The deputy manager said, "They have a service user meeting quite regularly, plus we sit and chat about day- to -day things, such as if they want to go to the cinema or not." Involving the person and their family members meant that a holistic view of someone's care had been gathered. Despite this information, care files did not contain any details of reviews that people had been

involved in the creation of their care plan. Therefore, recording of this information needed to be improved to demonstrate that this was happening. However, people were able to express themselves though the personalisation their rooms with their own furniture and personal items. One person said, "I can decorate it however I want to." Rooms were individual to the person and allowed them to express their interests.

Requires Improvement

Is the service responsive?

Our findings

Care files were not person-centred. They contained no background history or specific information about people which would help staff get to know them, such as information around their likes, dislikes and interests. By including this information, staff would be able to learn more about a person and be able to engage with them on subjects they are interested in and therefore provide personalised and responsive care. However, we found that staff knew about people's care needs and were able to tell us about any risks to them. For example, the deputy manager said, "I know the little signs – one person's feet change and become tense when they are upset or anxious." A relative also told us, "They know [my family member] as a person and how to look after them." This meant that current staff were aware of people's needs but any new staff would have found it difficult to identify people's current likes, dislikes and needs.

People's wishes around the end of their life were unknown as they had not been documented. We saw no evidence of any end of life care plans within people's care files. The deputy manager said, "No we don't record anything like that." Although people were not currently receiving end of life care, their advanced wishes had not been recorded. This meant that in the event of a sudden decline in health, people's wishes would not be known and therefore carried out.

We recommended that the provider ensures that care plans are person centred and include end of life wishes.

People were supported to attend activities that were meaningful to them. One person told us, "I go to college now. I do computer work. I like walking round the lake, feeding the ducks. At weekends sometimes I go to the pub and get a diet coke." Another person said, "We go on holiday. We went to Lanzarote last year. We're going to Bournemouth this year." People had opportunities to take part in leisure activities which they enjoyed including shopping, eating out, visiting the cinema and taking an annual holiday. Two people attended day centres each week and one person attended college. One person only had scheduled activities on one day a week but told us that they was happy with this and did not want any more. This mean that people had their choices listened to and respected.

People were supported to raise any concerns or complaints. One person told us, "I tell them about some things and I know I can tell them anything I want." One relative told us, "I've never had to complain but I would feel comfortable to if I had to." A staff member said, "Our service users are very clever and they know to come to us if there is a problem." The deputy manager told us, "It's brought up at the service user meetings, plus people here know that they can just talk to us any time." The service had not received any recent complaints, but had received a compliment from a relative. This read, "I was impressed by the calm and positive manner that [a staff member] maintained during our visit. Her smile and composure helped bring [one person's] to a better mood in the end."

Inadequate

Is the service well-led?

Our findings

People, relatives and staff told us they felt the registered manager was approachable and supportive. One person told us, "He's all right. He's been good to me. He's helped me with my health. He takes me to my doctor to see how I'm doing." One relative said, "I think he's fine. [The deputy manager] is very good. They do a lot for [my family member]". Another relative told us, "They seem pretty good, I have no complaints there. I've always had a good relationship with the managers there." Another staff member told us, "I think they need to focus more as it takes a long time for things to be done. They need to be a bit more proactive."

However, effective systems were not always in place to assess, monitor and improve the quality of service people received. A staff member told us, "I make management aware and sometimes things aren't done but I keep nagging." The director of the service had completed three visits to the home in 2018 to check the quality of care and people's and staff's experiences at the service. The director had not identified the issues we found and the feedback in each report had mainly been the same. There was no record of reviewing and resolving issues that had been found in the previous visit. For example, a quality assurance visit record in May 2018 stated, "There is a need to repair the Nurse Call in Conservatory." However, this was not reviewed in the following quality assurance visit in July 2018. Therefore, there was no record of whether the issues identified had been resolved.
The provider's quality assurance record from May 2018, July 2018 and November 2018 all stated, "There were no major issues with Service Users records". However, as described previously in this domain and other areas of this report, we found there were issues with service user records and care files that needed addressing. The provider also checked the quality of medicine storage. The record from the visit stated, "My audit of Management of Medicine in the home entails checking issued and expiring date plus whether PRN Medication had been given and if they complied the company's Policy." Therefore, the provider had not identified the issue we had found with storing medicines at a safe temperature, nor the issues identified with the pharmacy around incorrect stock counts of medicines.

Care plans for people did not always reflect their health needs. People did not have care plans which detailed the care and support they needed in different areas of their lives, such as health (including mental health), nutrition, hydration or communication. People's care files contained 'protocols' but these acted as risk assessments with actions staff should take to minimise risks. The deputy manager told us that one person had epilepsy. While there was a 'protocol' around this, there was no care plan around this containing information on how frequent the person's seizures were and what staff should do in the event of a seizure.

Another person's emergency plan for mental health episodes stated they had an allergic reaction to a certain medication. However, their hospital passport stated that they had no known allergies. This meant that staff would not always be aware of how a person's health need would affect the care they required. This applied particularly to new staff who had no background information or knowledge of this person.

Records were not always accurate. Care files for people contained out of date information and were disorganised This could put people at risk of harm as staff would not be aware of their up to date health and care needs. Records around the running of the service were also not complete. As referenced earlier in this

report, information regarding emergency plans, accidents and incidents and safeguarding logs were not being completed. This could put people at risk.

The registered manager aimed to engage people and relatives in the running of the service. Relatives told us that they were asked for their feedback. A relative told us, "There is a questionnaire that comes around that I'm asked to complete annually. I think there's a continuous dialogue where we think about how things can be improved." Another relative said, "I know they send [a questionnaire] to a family member to complete sometimes." Residents meetings occurred monthly, where people were asked if they were happy and if there was anything they would like to suggest.

Staff were not engaged in the running of the service. A staff member said, "Staff meetings are usually every two months." Another staff member said, "Staff meetings happen one in three months unless there is an emergency." However, there had been a gap of seven months between the last meetings without any explanation for this. Staff discussed a variety of topics within the meeting, but minutes did not consistently capture which staff members attended and if any actions came from points made. For example, a meeting in December 2018 identified "medicines should be counted every day." However, this was not identified as an action point and was not occurring on our inspection, and was also picked up by a recent medicines audit that this was still not occurring. Therefore, resolutions to issues raised in meetings were not being implemented.

Registered providers should be meeting the standards set out in the regulations and display the characteristics of good care. However, we had identified shortfalls with risks to people, staffing, consent to care, respect and kindness, person-centred record keeping, responding to complaints and good governance within the service. This demonstrated there was a lack of management oversight of the service.

The failure to seek and act on feedback from people, effectively monitor the quality and safety of the service or maintain complete and contemporaneous records for people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The service had not notified CQC of all reportable incidents. There were two occasions where someone was found to have unexplained bruising and injuries. On another occasion, someone had burnt their hand causing blisters. These should have also been raised as safeguarding and injury incidents. This meant that the service was not reporting to CQC to ensure we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

There were plans in place to improve the service but a lack of staff to implement it. The deputy manager said, "I have ideas about how to improve the service and the support people receive, but I do not have opportunities to put these into practice as I'm always occupied providing support during my shifts." They were unsure when this would change. The service worked in close partnership with a local day centre so that two people could participate in activities. However, there was no partnership working with organisations that could offer entertainment and activities within the service. This would improve people's wellbeing.

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 service had failed to inform us of notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service failed to provide care in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to provide safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to notify us and other relevant authorities of safeguarding incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service had failed to ensure that people had been recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had failed to provide a sufficient number of staff to meet people's needs. Staff had not received sufficient training or supervision.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to effectively monitor the quality and safety of the service or maintain complete and contemporaneous records.

The enforcement action we took:

A warning notice was issued.