Strathmore Care

Meyrin House

Inspection report

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Date of inspection visit:
26 May 2016
31 May 2016

Date of publication:
28 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Meyrin house provides accommodation and personal care for up to 18 older people. An unannounced inspection was carried out on 26 May 2016 and 31 May 2016. Some people living at Meyrin House had care needs associated with living with dementia. At the time of our inspection 15 people were living at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The home had a registered manager in place. 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.

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The manager could not demonstrate how the service was being run in the best interests of people living there. Arrangements in place to keep the provider up to date with what was happening in the service were not effective. As a result there was a lack of positive leadership and managerial oversight. Systems in place to identify and monitor the safety and quality of the service were ineffective as they either did not recognise the shortfalls or when they did there was a lack of action to rectify them.

Staff did not have the skills and experience, and they were not deployed effectively to meet the needs of people. We found that staff did not always have enough time to spend with people to provide reassurance, interest and stimulation. There was a lack of knowledge around supporting and caring for people living with dementia including understanding how it affected people differently and how each individual should be cared for to promote their wellbeing as far as possible.

Views about staffing levels were mixed and some people felt that there was not enough trained and experienced staff available to meet their needs. We also found that people or their families were not fully involved in planning and making decisions about their care. We found the service not to be responsive in identifying and meeting people's individual care needs.
The dining experience was varied as it did not meet all the people's individual nutritional needs. As a result the manager and Provider were unable to demonstrate that people had enough to eat and drink to support their overall health and wellbeing.

Although relatives told us that staff treated people with kindness and were caring, we found the way the service was provided was not consistently caring. Staff did not always demonstrate a caring attitude towards the people they supported and some failed to promote people's dignity or show respect to individuals. The majority of interactions by staff were routine and task orientated and we could not be assured that people who remained in their bedroom received appropriate care to meet their needs. This also meant they were socially isolated as opportunities provided for people to engage in social activities were limited.

Whilst we were concerned that some staff did not always recognise poor practice, suitable arrangements were in place to respond appropriately where an allegation of abuse had been made. There was a system in place to deal with people's comments and complaints however we found the service needed to be more open and transparent in their responses.

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 consistently safe.

People were not always protected against the risks associated with medicines because the Registered Manager did not have appropriate arrangements in place to manage medicines safely.

Although staff knew how to recognise and respond to abuse correctly, not all people felt safe and we found that the arrangements to keep people safe were robust. Individual risks had not always been correctly assessed and identified. There were no effective systems in place to reduce the risk and spread of infection.

The recruitment process was robust which helped make sure staff were safe to work with vulnerable people. The deployment of staff was not appropriate to meet the needs of people who used the service.

We found people's medicines were managed and stored safely.

Is the service effective?

Inadequate

The service was not effective.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service. Staff training provided did not always equip staff with the knowledge and skills to support people safely.

Improvements were required to ensure that staff recognised people's deteriorating healthcare needs and made sure that appropriate healthcare professionals were contacted at the earliest opportunity.

People's dining experience was always positive. People did get the support they needed with meal provision. However people did not appear to be given a choice of meals nor could we evidence people being supported in decision making.

Is the service caring?

Requires Improvement

The service was not caring.

Not all care provided was person centred, caring and kind.

People and those acting on their behalf were not always involved in the planning of their care.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Staff were not consistently responsive to people's needs.

Arrangements were in place for the management of complaints however they had not proved effective.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance system was not effective because it had not identified the areas of concern and there were no plans in place to address them.

The manager and senior staff lacked knowledge of the requirement to notify the Commission of incidents and both expected and unexpected deaths.

People's records were stored securely.

Meyrin House

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 registered manager was 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 the 26 May 2016 and 31 May 2016 and was unannounced. The inspection was undertaken by one inspector.

We reviewed other information that we held about the service such as notifications. These are the events happening in the service that the registered manager is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

As part of the inspection we spoke with two people who used the service, three relatives and six members of care staff and the registered manager. We also spoke with the Local Authority's contracts team.

Some people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. We therefore used observations, speaking with staff, and relatives, reviewing care records and other information to help us assess how people's care needs were being met. We spent time observing care in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of this inspection we reviewed six people's care records. We looked at the recruitment and support records for three members of staff. We reviewed other records such as medicines management, complaints and compliments information, quality monitoring and audit information and maintenance records.

Requires Improvement

Is the service safe?

Our findings

During our inspection we had concerns about the amount of staff available to meet people's care and support needs. The service was not being safely and effectively delivered because staff were rushed and did not have time to meet people's needs, for example we observed some people shouting who were clearly distressed but staff were unable to provide them with comfort or support as their duties were wholly task orientated. People's and relatives' views on staffing levels were mixed. Another person informed us, "There is only three staff on duty during the day and two at night." They went on to say, if two members of staff are busy attending to another person it means we are only left with one staff member to support everyone else. One relative told us, "There are times when it's obvious they're [the service] running short of staff, especially at weekends, and also at a bank holiday." Some people said that staff were not always timely in responding to emergency bells as they were supporting other people with either toileting or medication.

Where people required close monitoring due to high risk of falls or becoming anxious and distressed towards other people, there was not always a member of staff available to monitor or support people. We observed over a period of 10 minutes there were no staff in the main lounge where most of the people were, as they were either supporting people with toileting or medication. One person informed us, "I am no longer able to walk so I need support to get to the lounge; however I opt to stay in my chair as I have to wait for staff to come and help me."

We saw one person repeatedly try to stand up to leave the communal lounge so they could wander around the home. The person was seen to be unsteady on their feet and there were no staff available to provide support with their mobility needs, we observed the person grab onto armchairs and lap-tables as they mobilised around the room, staff intervened upon returning from assisting another person with toileting and assisted the person back into their chair. When we looked at their care plan we found that they were assessed to be at moderate risk of falls and risk assessment identified that they need staff to be present with all transfers and mobilising.

Staff's comments about staffing levels at the service were varied. Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us staffing levels were inadequate to meet people's needs and that this could be stressful especially when the home was at full capacity. One staff member informed, "During the day it is manic in here. You are lucky if you can get a break or just five minutes to gather yourself as we are constantly on the go" and, "We have to take people to the toilet, monitor the lounge as one person is always walking around and we need to keep a close eye on them as they will put themselves and other people at risk." Another member of staff informed us, "It is very busy during the day if we are not taking people to the toilet we are monitoring people who wander around the home and need to be monitored all the time as they put themselves and others at risk. We also have to carry out regular checks on three or four people who are all prone to falls."

The manager and senior care staff were unable to confirm how staffing levels at the service were calculated so as to determine the number of staff required on each shift. Although people's level of dependency was assessed and recorded each month, there was no systematic approach to determine the number of staff

required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances. After the inspection we wrote to the registered manager and the provider asking for clarity on how staffing levels were decided and calculated.

The provider sent us their policy in regards to determining the numbers of staff required to meet people's needs. Whilst we assessed that this provided appropriate staffing levels during the day shift, these levels were not maintained on the day of inspection and rotas we viewed showed that most days the staffing levels fell short of the numbers assessed as required. The manager informed this was to do with some staff being on annual and maternity leave; however recruitment for additional staff was underway. The staffing numbers at night were not sufficient to meet the needs of people using the service as there were only two members of staff at night and one person using the service had been assessed as requiring two to three members of staff for safe moving and handling procedures. This meant that should this person require care, they either would not receive support or other people would be left with no staff to assist should this become necessary. This also placed people at risk should emergencies arise for those who required two or more care staff, leaving others without emergency assistance.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff knew the people they supported and risks were identified to people's health and wellbeing, for example, the risk of falls, poor mobility and the risk of developing pressure ulcers, where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service. Staff we spoke to understood their general duties in regards to keeping people safe and were able to indicate how people may be at risk of harm or abuse and how they would go about protecting them and ensuring their safety. We found that some information was contradictory. For example, where one person was deemed to be at risk of falls we found that the person's falls risk assessment recorded them as being at moderate risk, however the provider's own risk assessment in relation to 'slips and falls' recorded them as being at low risk.

Staff we spoke with were unclear as to which assessment was accurate. In addition systems in place did not mitigate risks relating to the health, safety and welfare of people using the service. For example, checks were not in place to monitor and make sure that an analysis of accidents and incidents or falls were completed at regular intervals. However, the accident records for four people we viewed showed over a period of several months that they had experienced numerous falls or sustained an injury. No analysis of the information was in place to monitor potential trends, for example, the frequency of falls, the specific circumstances surrounding the fall and the actions to be taken, such as, referral to the local falls team or a discussion with the person's GP to review their medication. During our inspection we found that only one person had been referred to the falls team in the last six weeks, however we noted that the person had sustained six falls between January 2016 and April 2016 before a referral had been made to the falls team, this was also noted for another person. It was only due to our concerns being raised with the manager that a referral was made for another person whom we had identified as experiencing high number of falls. No risk assessment was completed detailing the actions to be taken to mitigate any risks to the person.

All of the above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff had a good knowledge of how to keep people safe and protect them from potential harm. They were able to indicate how people may be at risk of harm or abuse and how they would go about protecting them and ensuring their safety. Staff told us that they would escalate their concerns to the manager. If the

concerns were about the manager staff stated they would contact the provider and/or other external agencies, such as, Social Services. Staff knew about the provider's whistleblowing policy and procedures. Staff had all the information they needed to support people safely.

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

We observed a staff member during their medication administration duties and they did so safely, ensuring that people received their prescribed medications as required and in a timely manner. Staff administered medicines to people in a way that showed respect for their individual needs, for example, they explained what was happening, sought people's consent to administer their medication and stayed with them while they took their medicines to ensure that it had been administered safely. Staff had received training in administering medicines and had their practice checked periodically. We reviewed medication administration records for 15 people and found these to be in good order. Medication was stored and disposed of safely.

Inadequate

Is the service effective?

Our findings

Although staff training records showed and staff told us that they had received suitable training to meet the needs of the people they supported, this was not embedded in their everyday practice. Staff told us that the majority of the training was provided through 'in-house' or via the Local Authority. On the first day of our inspection we observed two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm on two separate occasions. We observed staff perform an unsafe mobilisation technique. The two members of staff were observed to drag lift a person to make them comfortable in their recliner chair. One staff member acknowledged that this was not the correct practice. Although records showed that each member of staff had received manual handling training, this showed that staff did not know how to apply their training and provide safe and effective care to the people they supported. Training being delivered was not effective. This was raised to the manager and senior care staff member during the inspection who both informed that both staff would be spoken to further and training would be arranged if required.

Several people were living with dementia, some in the early stages of the condition whilst others were living with more advanced dementia. Although staff told us they had received training relating to dementia, we found examples of poor staff practice which indicated a lack of understanding and application of the learning from training provided. For example, some staff did not communicate effectively with individual people or provide positive interactions. One person asked for support and staff were dismissive and walked out of the room without responding to the person, the person continued to call out for help. The training did not equip staff to communicate effectively with people living with dementia or those who had communication difficulties.

Although staff told us they had received regular supervision and appraisals in the past 12 months, staff did not always see the value of supervision as some issues they may have raised in previous supervisions had not been addressed or dealt with. For example some of the issues raised that had not been addressed included issues relating to staff practices, relationships and communication, for example, staff on the night shift informed that they had raised concerns about the practice of some day-staff not completing all their tasks and responsibilities such as putting away washed laundry meaning they had to done this during the evening shift. Nothing had been done to address this and issues continued. Staff also informed that there was not always enough time in the day for formal supervision to be undertaken effectively.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received an effective induction over two weeks depending on their role and responsibilities. This included an induction of the premises and training in key areas appropriate to the needs of the people they supported. We spoke with members of staff and they confirmed that they had completed an induction and that it had included opportunities where they shadowed a more experienced member of staff. This was so that they could learn how to support people effectively and understand the specific care needs of people living in the service.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at whether the provider had considered the MCA and DoLS in relation to how important decisions were made on behalf of the people using the service. Details on how to involve the person in decision-making according to their individual levels of understanding and preferred communication methods were included in each person's care plan. In addition an Independent Mental Capacity Advocate (IMCA) was available when required to advocate for people, to ensure that people's rights in this area of their care were protected.

The Registered manager had an understanding of the principles and practice of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. The registered manager informed us that they worked hard to ensure that people's needs and rights were respected. Appropriate applications had been made to the local authority for DoLS assessments. Where these had been agreed the provider had notified the Care Quality Commission. However when we spoke to senior care staff that were responsible for reviewing and assessing people's ability to make an informed decision, staff lacked knowledge on the MCA and DoLS despite having attended training. Staff did not understand the legal requirements of the MCA. Staff informed that they assessed people's physical ability to act on decision rather than people's understanding or ability to make an informed decision. Information relating to people's ability to make decisions, or the decisions that they may need help with was not clearly recorded. For example two people had been assessed as lacking capacity in their daily lives. This was inaccurate as we found that both people were able to make some decisions and choices about their care, such as, what clothes they liked to wear, where they would like to eat their meal, choice of food, the time they got up in the morning and the time they retired to bed and how they liked to spend the rest of their day.

We found mental capacity assessments on day to day decision making to be generalised on the basis of people's cognitive impairment diagnosis, for example, people had been deemed not to have capacity to make any day to day decisions due to them having dementia. Each individual's needs had not been assessed based on their varied capacity levels for example what clothes they liked to wear, where they would like to eat their meal, choice of food or if they understood what medication they took and why. In addition, no specific best interest decision meetings and assessments had taken place where people did lack capacity in some areas of their lives. The DoLS had also not been taken into account for all the people using the service. For example the manager and senior staff informed that a new bed with bedrails had been ordered for one person however no formal assessment had been carried out to ascertain if this was in the person best interest.

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

We spoke to the manager who could not demonstrate if the service had consulted people or their relatives as to what food and drink they would like to have or how it was prepare, however, the majority of people enjoyed the food provided at the service and made positive comments. One person told us, "I am not much of an eater, but the food here is good." Another person told us, "The lunch today was very nice." A visitor said there were always drinks and food available. At lunch time we observed staff with two people who needed

support with eating. They did this is a respectful manner and made conversation with the person and engaged in social conversation with the other people around the table.

In general people had received effective support to care for their healthcare needs from the GP, District nurse and end of life care team who visited people requiring support on a regular basis.

Requires Improvement

Is the service caring?

Our findings

Although some people and their relatives told us staff were caring and kind, our observations showed this was not always consistent. We saw that where people were not able to verbalise and staff interactions were limited in there frequency and not personalised. We observed that on occasions staff spent time talking with each other rather than interacting with the people they supported.

Not all people who used the service received interaction with staff other than being given a drink. Most people in the main lounge spent time either asleep or looking ahead without engaging in their surroundings. Staff did not support people in a person centred way, their responses and interactions with people were often task led and routine based. For example, people, at times, had to wait long periods before being supported and people were not being engaged and staff did not always spend time speaking with people or acknowledging them as individuals. We observed one person repeatedly calling out however staff would be assisting other people with personal care and could only afford them time as they walked past the person and would tell the person that they would get back. They did not return to speak with the person and find out what they needed, leaving them without their needs being met.

Although there were times when staff did not engage people and did not understand that this formed part of treating people in a dignified and respectful way, we noted that people were smartly dressed. Staff informed us that people's well-being and dignity was very important to them and ensuring that people were well-presented was an important part of their caring role. People were able to maintain contact and continue to be supported by their friends and relatives. People's relatives told us that they were able to visit the service at any time without restrictions.

People were asked for their views and were involved in their day to day care through being offered choice as far as possible in their daily lives. Some relatives we spoke with confirmed that they had been involved in care planning and felt their views were listened to. One relative told us, "The manager and care staff are always around if I have any questions." We spoke to relatives who informed us that the service always sought advocacy support when needed to ensure that people had an independent voice. In addition we found information on advocacy support posted around the home. This meant that people and their relatives had access to the information should they require it. An advocate provides support and advice to people and is there to represent people's interests.

Inadequate

Is the service responsive?

Our findings

People did not always receive care in a person centred way because the deployment of staff meant staff's approach was mainly task and routine focused. This meant that interactions between staff and people using the service were primarily focused around the provision of drinks and meals. Our observations throughout the inspection showed that there were few opportunities provided for people in regards to planned social activities. There was a lack of meaningful engagement and people were not supported to pursue their interests or hobbies. There were no activities in the afternoon on both days, with Manager and senior staff informing that family visits and watching television were the activities for each day. Our observations throughout the inspection showed that there were few opportunities provided for people to join in with social activities.

Throughout our inspection we found the main lounge to be uninviting and held little to occupy people present. The lounge had an institutional feel, with the chairs set out along the walls with a T.V. either end of the room. We spent five hours collectively observing the care of people who were sitting in the lounge. During this time both televisions were turned up loud and there was a delay on one of the televisions which was very disorientating. However staff did not seem to notice and did not intervene to change this for people. We did not observe (see or hear) staff offer any other form of activity or positive stimulation to any of the people sitting in the lounge. This meant people had no stimulation and minimal social interaction.

We found that people's care plans clearly identified their interests and likes in regards to social activities, however on looking at people's care plans and our observations on both days of the inspection it was not clear as to how people were being encouraged to have this need met. We spoke to people who used the service about activities. We were told that there was an activities co-ordinator before Christmas last year however they had left and since then there was not a lot to do apart from watching television or relatives visiting them. This was confirmed by staff we spoke to and also people's daily activities records. When we spoke to the manager they informed us that they were responsible for arranging and planning activities however nothing had been planned in the last few months. They provided an assurance that they would be looking at arranging some activities in the coming weeks. After the inspection we wrote to the provider to ascertain who was responsible to planning and arranging activities. The provider informed us that they were in the process of recruiting an activities co-ordinator however at present the responsibility lay with the manager and their staff.

The current provision of support for people to remain engaged and live full lives were inadequate and significant improvements were needed to ensure that all the people living at the service received support to engage in their favourite pastimes and live an active life.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that if they had any concern they would discuss these with the management team or staff on duty. People told us that they felt able to talk freely to staff about any

concerns or complaints. There was a policy and procedure in place and however we found people's concerns had not acted upon despite staff taking written statements. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. .

Although the above was positive, a record was not maintained detailing the specific nature of each complaint, there was not always evidence of the investigation, action taken and proof of how decisions and conclusions had been reached. In addition, the registered manager was unable to provide any evidence to show that all complaints received had been dealt with or responded to in line with the provider's complaints procedure. For example on two occasions care staff had documented concerns that had been raised by one relative. The relative had raised concerns that on a number of occasions they had visited their relative and found bruising on their member of family's hands, however staff had been unable to tell them how this had happened; in addition the manager acknowledge that the concerns raised had not yet been investigated. Additionally, a relative had also complained about some of the staff as being 'bossy and controlling'. They also informed us, "Several occasions whilst visiting I have had to intervene when another person has become agitated not only towards my relative but other people in the main lounge".

When we spoke to the manager during the inspection they acknowledged being in receipt of this information however had not investigated the concerns neither had they spoken to the relative about the concerns raised. No other information had been recorded and the manager was unable to provide any further evidence detailing the specific nature of the complaint, evidence of the investigation, action taken and proof of how decisions and conclusions had been reached. We considered the information provided and raised a safeguarding alert as part of our concerns to the Local Authority.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider did not have systems in place to assess, monitor and improve the quality and safety of the service for people. The registered manager acknowledged that the level of staffing in the home needed to improve to ensure that people's needs were being met. As this would also allow them time to focus on running the home and undertake managerial tasks. The service was not being effectively delivered by staff that were rushed and did not have time to meet people's needs, for example we observed some people were shouting and were clearly distressed but staff were unable to provide them with comfort or support as their duties were wholly task orientated.

The manager could not evidence any effective systems or processes which assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. The manager was unable to demonstrate how they continually analysed, evaluated and sought to improve their governance and auditing practices in line with their own quality assurance policy. The provider's quality assurance policy and procedure detailed that an audit of quality records including the personalised records for people using the service were maintained, monitored and reviewed. We found no evidence to show that these had been completed and both the manager and senior member of staff confirmed that this was accurate. Despite a number of effective monitoring systems in place it was evident that improvements needed to be made to improve the care and support people were receiving. Upon investigation the registered manager informed that they should have been carrying out monthly manager's audit, however this had not been the case as they had not had time to carry out their managerial role due to having to work as part of the care team as there had not been enough staff to cover shifts.

In addition the lack of use of the systems put in by the provider meant the manager and they staff were unable to mitigate risks relating to the health, safety and welfare of people using the service. For example, quality assurance checks were not in place to monitor and make sure that an analysis of accidents and incidents. The lack of staff input into people's daily lives had not been addressed. In effective staff supervision and training had not been identified to improve practice and keep people safe. Ineffective complaints procedures had not been identified and reviewed to improve responses to people's concerns and to prevent reoccurrence of incidents. Staffing levels and how this impacted on people's wellbeing had not been reviewed, leaving people without any meaningful input and staff not being able to deliver responsive and effective care. The lack of review and oversight of the application meant that people's rights and freedoms were not protected by the service.

It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. This showed that there was a lack of provider and managerial awareness and oversight of the service as a whole as to where improvements were required.

All of the above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was lack of clear leadership in regards to who was managed the service. The manager and senior staff lacked knowledge of the requirement to notify the Commission of incidents and both expected and unexpected deaths. No statutory notifications have been sent to CQC since August 2015 with the last one sent in May 2014. Despite this, it appears that several incidents of falls that had occurred within the service which had resulted in serious injury to people however the commission had not been notified under the provisions of the Care Quality Commission (Registration) Regulations 2009. Accident and incident forms we reviewed confirmed that the manager and staff were not notifying the Commission, other professionals and relatives when an incident had occurred. Manager informed that they were not aware that it a requirement under registration to notify CQC of any serious injuries or safeguarding concerns, this was also evidenced by her lack of knowledge what forms to complete and were to obtain them from.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Personal records were stored in a locked office when not in use. The registered manager had access to up-to-date guidance and information on the service's computer system which was password protected to help ensure that information was kept safe.

We found the registered manager to be open, transparent and highlighted their own errors and areas which needed to improve, to ensure the service was running smoothly and continually improving the care delivered to people. People felt that staff and the management team were approachable.