Oregon Care Limited

Redstone House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We last carried out a comprehensive inspection of Redstone House in July 2016 where we found the registered provider was rated 'Good' in each of the five key questions that we ask.

This inspection took place on 06 December 2018 and was unannounced.

Redstone House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service had not 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 were not supported to live as ordinary a life as any citizen.

Redstone House in Redhill is registered to provide accommodation and personal care for up to four adults who have a learning disability. At the time of our inspection four people live here. The service is delivered from a two-story house in a residential area.

It is a requirement of the provider's registration that they have 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. The registered manager was present during this inspection.

This inspection had been bought forward as we had received concerning information about peoples care and support needs not being met. During the inspection we found a number of issues that needed to improve, however the care staff were seen to be kind and caring to people.

We found areas that required improvement across all five of the key questions that we ask during an inspection (Is the service safe, effective, caring responsive and well led?). In total we have identified seven breaches in the regulations.

The breaches were around managing risks to people, while minimising the impact to their independence; not having enough staff at all times to meet people's needs; the safe management of medicines; not providing care and support that met people's needs and preferences; not providing information in an accessible format; failing to carry out maintenance to the home environment in a timely manner; and not having quality assurance processes that promoted continuous improvement.

The provider had not ensured the home was well led. Staff were focussed on giving day to day care, however

little structured and documented work had been completed to improve people's lives. All the people who live at the home had some form of behaviour that may challenge themselves or others. This meant that they required one to one, or even two to one support at times of the day. The providers failure to promote continuous improvement meant that although these behaviours were known and documented when they happened, people had not been supported to overcome them. The records of accidents and incidents had not been reviewed to try to reduce the risk of repeat concerns arising.

The providers quality assurance processes were not effective at ensuring areas for improvement that had been identified were actioned in a timely manner. Maintenance issues such as exterior doors not being able to be locked had taken months to fix leaving people at risk as the house had not been secure.

Redstone house did not provide a consistently safe standard of care. There were risks to people's health and safety because behaviours that may challenge had not been well managed. Although incidents had been recorded no structured approach had been taken to try to help people manage and overcome behaviours. Risk management also had an impact on people's independence as they were restricted from doing things themselves because staff had failed to investigate less restrictive options. For example, using small jugs, and small kettles/coffee pod machines to enable people to make their own drinks in a safe way, rather than staff having to step in and help. Guidance from health care professionals had also not been consistently followed effectively, or sought to help people overcome behaviours that impacted their lives.

Levels of staffing were not always adequate to meet people's needs. Prior to the inspection we received information that a lack of staff had impacted people's care and support. During our inspection, we identified times where people were at risk, or their activities delayed due to the deployment of staff. For example, a staff member supported one person to go to college, however this meant the other three people had to wait for them to return if they want to go out, due to their behavioural support needs.

People were not always supported to take part in activities that interest them. Where activities had ceased, due closure of a service, or people's behaviours meant they were excluded, alternatives had not been sought. Activities planners did not reflect the activities (or lack of) that people had access to. Care plans were basic and contained little information about the person as an individual, such as their goals and aspirations for their life. No information or guidance for staff had been obtained to ensure that peoples preferences and choices were know should they approach the end of their lives.

Peoples medicines were managed in a safe way and they received them when needed. However, staff did not always know what the medicine was for, or the possible side effects. They did know they could look in a person's care file if they needed the information, such as should a person have an unexpected reaction after taking medicine.

Staff had the skill and training to meet people's needs, although there were some gaps, and out of date training identified. The provider had already identified this and was taking action to give staff the training they needed.

There was a complaints process in place, however this was not in a format that would make it easy for people to understand. Everyone we spoke or interacted with was happy with the service, and no complaints had been recorded in the complaints file. There were three positive comments in the compliments file from relatives.

People were supported to have enough to eat and drink. People had access to health care professionals when the need arose, as well as for routine check-ups to keep them healthy. Where people lacked the

capacity to make specific decisions, staff understood and followed the requirements of the Mental Capacity Act 2005. This ensured that decisions made for people in their best interest and any restrictions put into place to keep them safe were done in a lawful way.

Despite the issues we found during the inspection we did see that people were supported by kind, caring and friendly staff. People formed caring relationships with staff and enjoyed their company. People were supported to maintain relationships that are important to them.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks to people's health and safety were not always well managed.

Reporting of incidents to the local authority safeguarding team had not taken place when it should.

There were not always enough staff deployed to meet peoples identified needs.

People received their medicines when they needed them, but some improvements were needed around staff knowledge and how the giving of 'As Required' medicines are documented.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment had not been suitably maintained and repairs had not been completed in a timely manner.

Guidance from health care professionals was not always followed, or results reviewed to improve people's care and support.

Staff received training to help them meet people's needs. Some of this was out of date, which the provider was addressing.

People were supported to have enough to eat and drink.

Where people were unable to make decisions for themselves, the process of the mental capacity act had been followed.

Is the service caring?

Requires Improvement

The service was not always caring.

Some aspects of staff support meant people were not treated in a dignified way.

Peoples independence was not fully supported, as adjustments or use of equipment had not been considered to give them more control over tasks.

Staff knew the people they cared for and we saw many positive interactions during the inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support plans were not person centred, nor gave any indications of goals and aspirations people may have. This meant they were task focused with no recording if support had made a positive impact to their quality of life.

There had been no complaints from family or people who used the service, however the complaints policy was not in a format that people could understand.

People's preferences for end of life care had not been addressed.

Is the service well-led?

Inadequate

The service was not always well led.

Quality assurance processes did not always identify issues, or promote continuous improvement.

People were not engaged in how the home was run because 'house meetings' were not in a format they could understand.

Partnership working with outside agencies was not successfully making a positive improvement to people's lives.

The registered manager had not kept up to date with best practice ideas from across the care sector.

Redstone 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 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.

The inspection was prompted in part by notification of an incident following which a visitor to the service raised concerns over the staffing levels, and how this had impacted the care people received. This inspection examined those risks.

The inspection took place on 06 December 2018 and was conducted by one inspector. It was a comprehensive, unannounced inspection.

We reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority.

Before the inspection visit, the provider completed a Provider Information Return (PIR). 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 This enabled us to ensure we were addressing potential areas of concern at our inspection. The PIR was detailed and we were able to review the information in the PIR during our inspection visit. We found the information in the PIR did not accurately reflect how the service operated.

During the inspection visit we spoke or interacted with all four people who lived at the home and observed how care and support were delivered in the communal areas. We spoke with the registered manager and two care staff.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at other records related to people's care and how the service operated, including

three medicine records, two staff recruitment files and the provider's quality assurance audits.

Inadequate

Is the service safe?

Our findings

People were not always kept safe. The risks of harm related to people's health and support needs had not been consistently reviewed or well managed. Staff were observed to move a person in a wheelchair. They had not ensured the foot plates were in place, which risked injury to the person's feet and ankles. We immediately stepped in and stopped them moving the person. Risk management at the home also limited people's independence. For example, when people made drinks for themselves, staff had to assist with milk bottles and kettles as they were too large for people to manage themselves. As staff were not always present in the kitchen area, there was a risk of people coming to harm through scalding. No consideration had been given by the staff to using small milk jugs, or small kettles/coffee pod machines, so that people could make their drinks themselves in a safe way.

People's response to external stimuli that prompted behaviours that may challenge were documented by staff. However, the triggers for these had not been fully explored to try to help people manage the risk to themselves and others. All the people living at the home could display behaviours that could put them and others at risk of harm. Examples of these behaviours included taking drinks from others, which could cause a reaction from the person who owns the drink. This is also unhygienic as the person, once they had the cup, tried to drink out of it, even if it was empty. This can happen in any environment the person is in, for example when out in the local community.

Other behaviours people had included self-harming, and inappropriate behaviour when out in the local community (and at the home). This included approaching strangers in public and making physical contact. This could result in physical harm to the person if the stranger reacted badly. Another example was where when one person became distressed they could smear their bodily fluids around the environment, putting themselves and those in the area at risk of spreading infection. Behaviour charts were in place to record when these incidents took place, but no work had been done by the staff or with behavioural specialists to try to help the people overcome them.

The registered manager and provider had not reviewed accidents and incidents with a view to prevent reoccurrence. This was demonstrated by completed behaviour charts (for the behaviours detailed above) not actually having any analysis, to try to understand what had happened and what support was needed to help people manage this aspect of their lives.

People's medicines were not always managed safely. Where people had been prescribed medicines on an 'as required' basis, such as to relieve pain, plans were not always in place. This meant there was a risk that they could be given too often. Recording of when medicines had been given was also inconsistent with gaps being identified in the medication administration records.

Staff giving the medicines were not able to explain the possible side effects, nor consistently identify what each medicine was for. There were only four people living at the home and the majority of staff had worked there for some time, so should have had this knowledge. Staff did know that they could look in the person's file for the information if they had any concerns.

Risks to people's safety had not been managed because essential fire safety equipment had not been adequately maintained. A bedroom door closure device to ensure the door would close in the event of a fire was not working. It made a bleeping sound which indicated the battery needed replacing. This was beeping on the day of the inspection and had been beeping when the local authority had visited the home the week before. In the event of the fire alarm going off, this could cause the door not close. This would mean the person in the room would not be protected from smoke inhalation, nor have any protection from fire spreading into their room.

Prior to our visit we had been made aware that the building was not secure, due to issues with exterior doors. People would have been at risk as the exterior doors could not be locked. This had been rectified by the time of our visit, but this had taken several months for the provider to arrange. In addition, on arrival at the home the front door could not be opened, and a lock smith was required to replace the lock on this door and an interior door leading to the conservatory. The front door was the main exit in the event of a fire. This was fixed before we left at the end of the inspection.

The Failure to manage risks to people's health and safety, and lack of safe management of medicines was a breach in regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not kept safe from the risk of abuse. Staff told us they understood their role and responsibilities with regards to keeping people safe from abuse. However, staff had not recognised that incidents such as people hitting each other, or unexplained bruising should have been reported to the local authority safeguarding team. There had been eight incidents of this nature recorded on accident forms between March and October 2018. Policies in relation to safeguarding and whistleblowing reflected the local authority's procedures and were clearly displayed in the house, but staff had not reported as required by those policies.

Failure to identify and report safeguarding incidents was a breach in Regulation 13 (Safeguarding people from abuse and improper treatment) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff deployed to keep people safe. During our inspection although staff were in the building there were times when vulnerable people were left on their own. One example was where staff had a meeting in the office with the door closed. This left one person with behaviours that challenge in the lounge with the inspector, and a visiting tradesman. During a recent visit by the Surrey Quality Assurance Team, there had been only one staff member on duty, with three people being supported in the house.

A review of the staffing rotas covering the period between August 2018 to November 2018 showed multiple times where only two staff had been on shift at busy times such as first thing in the morning when all four people were in the house, or at weekends. For example, on the Saturday 10th November 2018 only two staff were on shift between 9am and 8 pm, with only one on shift between 8am and 9am. This was below the calculated safe staffing levels as set by the registered manager, and the assessed needs of the people from the local commissioners of the service. The registered manager told us that three staff were the minimum safe level when everyone was in the home. In addition, when one person was supported to go to college, the staff level in the home dropped to two staff for three people. This impacted these people's support as one person requires two to one support when outside, and another person requires one to one support when out in the local community. This would be impossible for staff to achieve with the current staffing levels.

Failure to have sufficient numbers of staff deployed at all times was a breach in Regulation 18 (Staffing) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was in place, however no easy to read formats had been developed to try to help people understand. At the time of the inspection the home was clean to reduce the risk of spreading infection, however the risk posed by people's behaviours had not been well managed.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that potential staff were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

Maintenance of the environment was not effective at ensuring it was suitable for people. There were spots of damp on the stairs, and a leak in the ceiling of one bedroom. Multiple issues in decoration and suitability of furniture for people were identified around the home. This included people not being able to reach light switches without staff help; beds not being a suitable height for people (one person required a step to get into and out of the bed as it was too high for them); missing tiles in bathrooms; and radiator covers and cable covers coming off the walls. A concern had been made prior to the inspection about one person's room. This was due to the smell and cleanliness as the person did not always use the toilet when passing urine or faeces. This was being decorated at the time of our inspection and a new floor had been ordered to address the concerns that had been raised.

As the premises had not been properly maintained in a timely way, and equipment such as furniture and furnishing were not always suitable for the people that used them there was a breach in regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager assessed the needs of people before they moved into the home. No new people had come to live at the home since our last inspection. This would ensure that their needs could be met, and equipment or modifications to the home could be installed before they arrived. However, as we have detailed above, this was not effective for the people who currently lived in the house. The assessment involved meeting with people and those important to them. This also gave the opportunity to check if any special action was required to meet legal requirements. For example, when using specialist medicines, or meeting the requirements of the Equalities Act.

People were supported by trained staff that had some knowledge and skills to enable them to care for people. Ongoing training and refresher training was in place, however some of this was out of date, or had not taken place. This had been identified by the provider and action was being taken to address the issue. Staff had regular supervisions (one to one meetings with their manager) to discuss training needs, and give them the opportunity to discuss their role with their manager. However, as we have identified in the safe domain, some improvements were required around staff's knowledge of medicines and moving and handling procedures.

People were supported to have enough to eat and drink. During the inspection people were offered drinks and snacks throughout the day, including fresh fruit. Breakfast on the day of the inspection for one person included cereal of their choice, followed by toast and marmalade. People were involved in the preparing the food and drinks they wanted with staff support where needed. As we have shown in the safe domain some improvements could be made regarding promoting people's independence. People's cultural or regional preferences were also explored. People's weights were monitored and the monthly notes recorded that people's weights had remained stable. This indicated they were receiving enough to eat.

People had access to health care professionals to help keep them healthy. Each person had a health action plan to record when routine health checks had been attended, or were due. This included dentists,

chiropodists, opticians and audiologists. Each person also had a 'hospital passport' in place. This gave important information about the person that could be passed onto other services, such as hospital staff. People could see the GP if they felt unwell, and were supported to attend appointments at hospitals and specialist consultants when needed. Staff worked effectively with the health care professionals to support people when they became unwell.

The 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. Capacity assessments had been completed for specific decisions such as where a person was not able to leave the house without staff support.

Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. Staff had an understanding of the Mental Capacity Act 2005 including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff asked for people's consent before giving care and support throughout the inspection.

Requires Improvement

Is the service caring?

Our findings

People had not always received compassionate care and support from staff . The failure of the provider to give a consistently safe, effective, responsive and well led service resulted in people not living in a caring service. There were also areas were care staff could improve with regards to promoting independence and being mindful of people's dignity.

People's dignity was not always protected by staff. People were preparing to go out during part of the inspection. As people were preparing to go out staff gave them continence pads in the dining room in the presence of the inspector and a visiting tradesman. Staff had not considered this was not dignified for the people concerned. We discussed this with the registered manager and suggested perhaps having the pads in people's rooms, or if they must be given out away from the bedroom, then to use a discreet bag, such as a handbag for the people to carry them in a dignified way. The registered manager said they had not thought of that.

Information about people's care and support was not always given in a manner they could understand. Key information such as safety information (fire safety, keeping safe from abuse), complaints and care records had not been made in an easy to read, or other format, suitable for the individuals to try to help them understand. Staff had a good rapport with people they supported and could communicate using simple sign language. However, agency staff were used at the home, and there were no communication tools in place, such as picture boards to help with communication.

Failure to provide key information to people in an accessible format and not always treating people with dignity and respect was a breach in Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some good interactions by staff that had protected people's dignity. For example, when getting people ready to go out staff brushed their hair and made sure their clothing was tidy and clean.

Staff could tell us about the people they supported without access to the care notes, including their hobbies and interests, as well as medical support needs. We could see that positive and caring relationships had been formed. People enjoyed the company of the staff who supported them. Staff acted in a professional way, but also showed compassion to people, such as by holding their hands, comforting them if they became upset, or giving a hug (which the person clearly appreciated by the smile on their face.)

People were involved in decision making about their care, and their independence was supported, however improvements could be made. An example of promoting independence was where people were prompted to prepare their own breakfast. This included choosing their own bowl, the cereal they wanted to eat and getting the milk from the refrigerator. However other aspects of maximising people's independence had not been explored. This included making hot drinks, or helping them understand and overcome their behaviours to help them have more control over their own lives. This has been detailed in the safe domain.

The registered manager and staff were caring and attentive with people. When people came out of their rooms after waking up, staff welcomed them as they came down the stairs. Where people showed signs of distress the registered manager responded to stop this progressing. One person was waiting for staff before they could go out. Staff were working out the money that would be needed for the trip. The person took themselves to the corner of the lounge and began to hit themselves gently on the forehead. The registered manager saw this and immediately attended to the person. They also told staff to stop what they were doing, as that could be sorted later and take the person out. This resulted in the person calming down, and their behaviour did not progress to the next stage. This emphasised the importance of having enough staff at all times, as if the registered manager had not been in the room, the person may have become more distressed.

Another example where staff showed compassion and understanding of people was when one person went to hug another in the lounge. The person clearly did not like the contact, so staff immediately intervened. They then took time with both people to talk through what had happened. Staff explained to the person that had given the hug they should respect other people's personal space. The result was that both people came away from the incident being calm and understanding what had happened. All the staff were seen to talk to people whilst carrying out their duties, or taking time away from their duties to talk with them.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive a level of care and support that responded to and addressed their needs. This impacted people because they had not been supported to overcome their behaviours which meant they did not have as full a life as possible.

Care plans for people were basic and not person centred, nor had staff adequately implemented guidance from professionals. Information for staff did include aspects of care and support, such as how to respond if people displayed behaviour that challenged, as well as what tasks people should be encouraged to do for themselves. However, there was no information about who people were as individuals, or what their goals or aspirations were. The care plans were task focussed. Where advice and guidance had been given by health care professionals this was not consistently followed, and no work had been done to use the information to help people overcome their issues. For example, to help manage people's behaviour 'ABC' charts were used. The results had not been analysed to see if anything could be done to help the people manage their behaviours, or if behavioural specialists could help. Where people's medical needs required recording of bowel movements, this had not been consistently done by staff.

Care plans addressed areas such as how people communicated and how their conditions may appear and affect their behaviour. They went into detail on how staff should respond, such as reassuring and talking to the person. Care given to people on the day of the inspection matched with the guidance in the care plans.

People did not always have access to activities that interested them, or stopped them being bored. One person was supported to attend college, however this impacted other people as the staffing levels meant they could not go out individually until the staff member returned from taking them to college. Each person had a 'timetable' of activities however the registered manager told us that many of these no longer took place or did not happen as often as the planner suggested. This included swimming and bowling which had not taken place, as evidenced by no mention of them in daily care records . This change in activity was for a number of reasons, such as staffing levels, or people no longer wanting to do the activity. However, no record had been kept of the reason these activities no longer took place, nor if alternatives had been sought for people, such as when services closed. People did have access to some activities, for example on the day of the inspection three people went to the cinema with staff, and were due to attend a local disco in the evening.

People could not be assured that their preferences and choices would be known at the end of their lives. No end of life training for staff had taken place and end of life care plans had not been developed to record preferences and choices that people had for the end of their lives. This meant that should people's health deteriorate suddenly staff may not know the persons wishes. Staff had not tried to discuss the topic with the people, or their family members.

Failure to provide care and support that would met people's preferences and needs was a breach in Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that listened to and would respond to complaints or comments.

There was a complaints policy which included guidelines on how and by when issues should be resolved, but it was not in an easy to read format to help people understand it. It contained the contact details of relevant external agencies, such as the CQC. There had been no complaints since the last inspection. Three compliments had been received in 2018. One of these stated, "[Person's name] is very happy here and is always talking positively about the staff."

Inadequate

Is the service well-led?

Our findings

The providers quality assurance system had not ensured that people received an overall good standard of care. The provider had quality monitoring in place for four key areas of the service provision. These were for 'people who used the service', the 'staff team',' health and safety' and 'Regulation 26' (which references an old regulation no longer in existence).

The last quality monitoring check was dated July 2018. This recorded that care plans were person centred and that this was evidenced by the home having a copy of the person-centred planning guidance from the 'foundation for people with learning disabilities.' The care plans we saw were not person centred. The monitoring check did not identify that people were not fully involved in how the home was run. Regular house meetings took place which recorded that three of the four-people showed no interest or understanding of the meeting. For example, when asked a question the minutes recorded that the person didn't respond and 'picked at their sleeve.' No alternatives had been investigated to see if alternative methods for involving people in the home could be found.

The providers quality assurance processes had proved ineffective. They had either not identified the issues we found or had taken far too long to address issues when they had been raised by the registered manager. The monthly health and safety checklist completed in November 2018 made no reference to any issues with regards to furniture and fittings around the home not being in good repair, nor the risk to people from having exterior doors that were unable to be locked. The health and safety audits recorded that the issue with the exterior doors had been raised with senior managers in June 2018, but had not been resolved in December 2018. The damp patches and ceiling leaks in bedrooms had been reported to the senior management in July 2018, and again was still an issue in December 2018.

Continuous improvement processes were not implemented effectively by the provider. During the inspection the registered manager showed us a number of policies and procedures that had recently been developed. They explained that they had signed up to a service that kept them up to date with best practice. However, when we reviewed the new policies with the registered manager we saw that they were generic and only individualised to the service by the provider putting their name on them. The registered manager and staff team had not read them, nor ensured they were followed. For example, the policy on reporting accidents referred to forms that needed to be completed, but these had not been printed off so were unavailable to staff. The need to fill these forms in had not been noticed by the registered manager or provider demonstrating the documents were not being used and best practice was not being followed.

Successful partnership working with other agencies was not embedded within the home. Feedback from health care professionals raised concerns around many aspects of peoples care and support. These were confirmed during our inspection, as has been detailed through this report. These partnerships had not been used improve the service. The registered manager said that they had stopped attending conferences and meetings due to costs. This meant they had not kept up to date with current best practice and had no opportunity to share information and learning with peers from other organisations.

The Provider Information Return (PIR) had been completed in March 2018. The information given to us by the provider in this document did not reflect our findings on the day of the inspection. For example, in the effective section of the PIR the provider had stated that staff were to attend palliative / end of life training, however this had not taken place nine months later, nor was a date fixed for when this was to take place. The caring section of the PIR stated that the service would, 'Encourage Service users to take on new ventures and challenges.' This had clearly not been done as activities for people were limited. This also linked to the responsive section of the PIR that stated, 'To try to assess more opportunities in the community for the service users.' This had not been done.

Failure to adequately assess, monitor and improve the quality and safety of the service was a breach in Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were confident in their roles and felt supported by the management and had a clear understanding of their roles within the organisation. The registered manager had a caring disposition to the people she supported however the culture of the home was not focussed on improving people's lives. Instead it was currently centred on meeting people's day to day needs. As this report has demonstrates this had not always been successfully achieved.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to provide care and support that met people's preferences and needs. Failure to provide key information to people in an accessible format

The enforcement action we took:

We issued a Notice of Proposal to impose positive conditions on the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to manage the risks to people's health and safety

The enforcement action we took:

We issued a Notice of Proposal to impose positive conditions on the service.

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 Failure to identify incidents as possible safeguarding and not referring to the appropriate authorities.

The enforcement action we took:

We issued a Notice of Proposal to impose positive conditions on the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises had not been properly maintained, and equipment such as furniture and furnishing were not always suitable for the people that used them

The enforcement action we took:

We issued a Notice of Proposal to impose positive conditions on the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to adequately assess, monitor and improve the quality and safety of the service

The enforcement action we took:

We issued a Notice of Proposal to impose positive conditions on the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to have sufficient numbers of staff deployed at all times

The enforcement action we took:

We issued a Notice of Proposal to impose positive conditions on the service.