Quest Haven Limited

Quest Haven Limited - 31 High Street

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

Quest Haven – 31 High Street 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. Quest Haven – 31 High Street provides residential care for 5 people with learning disabilities. At the time of our inspection there were 3 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 4 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 always being managed appropriately and staff did not follow the guidance in people's risk assessments. There was no monitoring or analysis of accidents and incidents that had taken place to identify trends and reduce further risk. 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. Safeguarding procedures were not always followed and appropriate referrals were not made to local authority. People's concerns were not being investigated and therefore leaving people at risk of abuse.

There was not a sufficient number of staff to meet people's needs. Some staff did not receive adequate breaks between shifts.

Safeguarding procedures were not always followed and appropriate referrals were not made to local authority. People's concerns were not being investigated and therefore leaving people at risk of abuse.

People had access to a wide range of healthcare professionals, such as GPs, dentists and opticians. The recording of healthcare appointments was not always accurate.

Medicines were appropriately stored and managed. There were no gaps in Medicine Administration Records (MARS) and protocols were in place for 'as and when' medication. People were being cared for by staff who were aware of and carried out safe infection control processes.

Staff were not up to date with their mandatory training, and records of training did not reflect the

information staff gave us around their training. We did not see evidence that staff were receiving supervision and appraisals. People's rights were not protected. The service did not follow the Mental Capacity Act principles and correct legal authorisation had not been sought to deprive people of their liberty. The adaptation of the premises was suitable to meet people's needs effectively. However, the environment could be made to feel homelier.

People's rights were not protected. The service did not follow the Mental Capacity Act principles and correct legal authorisation had not been sought to deprive people of their liberty.

People had a choice of foods, and their weight was monitored regularly. However, people did not have free access to food and drink when they wished it. People and their relatives were involved in the review of their care. However, this was not recorded in people's care files. People were not always treated with kindness, respect or dignity. However, relatives were very complimentary of staff.

Care plans were not person-centred and did not include any detail around people's end of life wishes or health diagnosis. Because of this, staff were unaware of people's medical conditions. Complaints were not responded to in line with the providers policy. However, relatives felt that they have received a satisfactory outcome.

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 had physical altercations.

Staff and relatives felt that the registered manager and deputy manager were approachable. Staff felt valued. There was partnership working with a local day centre. However, more could be done in relation to activities that took place inside the service and meaningful activities. Plans were in place to expand the service. However, issues we found during our inspection should be resolved first. We did not observe any pre-assessments as people at the service had been living there for many years.

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

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 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 safe.

Risks to people were not being managed appropriately. There was no monitoring or analysis of accidents or incidents.

There was not a sufficient number of staff to meet people's needs. People did not receive the one to one support they were entitled to.

Safeguarding procedures were not followed and appropriate referrals were not made to local authority.

Infection control procedures were not always safe.

Medicines were appropriately stored and recorded.

Is the service effective?

Inadequate

The service was not always effective.

People's rights were not protected. The service did not follow the Mental Capacity Act principles.

Staff members were not up to date with their mandatory training. They had also not completed additional training on the health needs of the people they cared for.

Appointments with healthcare professionals were not always accurately recorded.

People were encouraged to maintain a healthy diet and weight.

Relatives and staff felt that communication was effective.

Is the service caring?

Requires Improvement

The service was not always caring.

Despite positive comments from relatives and staff, people were not always treated in a caring manner.

People's dignity was not always respected, and their independence was not always encouraged.

People and their relatives were involved in reviews of their care.

Is the service responsive?

Inadequate

The service was not always responsive.

Care plans were disorganised and not person-centred. They did not include details around people's medical conditions so staff were unaware of people's medical needs.

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

The service did not respond to people's complaints in line with their complaints policy.

Is the service well-led?

Inadequate

The service was not well-led.

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

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

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

There were plans in place to expand the service through a new two bedded extension.

Quest Haven Limited - 31 High Street

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 4 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. We needed to be sure that 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

During the inspection we spoke with two 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 details regarding staff's training. We also spoke to two relatives and a staff member over the phone.

Inadequate

Is the service safe?

Our findings

People and relatives told us that they felt the service was safe. One person told us, "I like living here." A relative told us, "[My family member] is safe there. I know that because they are happy." Another relative said, "Yes, I absolutely feel [my family member] is safe. I know the staff well and the manager. The staff are amazing with [my family member]." A staff member said, "I feel people are safe as they're well looked after by staff. It's a small service it's easier to manage." However, we found evidence that people were not always cared for in a safe way.

Risks to people were not always being managed appropriately as staff were not following people's risk assessments. One person's risk assessment stated that they were at risk of "jumping out of windows" and all windows in the building should have locks on them. However, we found that windows in the new extension of the building did not have these.

One person's care plan stated that they required supervision with certain visitors due to the behaviour that they may demonstrate towards them. However, we were not made aware of this risk when we first arrived at the service which led to an incident on the day of the inspection. When we informed the staff member of this incident they did not react appropriately to this and did not manage the risk for the remainder of our inspection. This meant that risk assessments were not being followed which consequently left visitors at risk as well as the people living at the service.

Furthermore, another person's care plan said that "all electrical equipment to be removed from his bedroom to stop him fiddling with and also getting him aggravated". However, on the day of our inspection, this person showed us the new radio that was in their bedroom. The staff member told us, He gets frustrated with it and has already broken it a couple of times." When we asked if this should be in their room as it was not in line with the risk assessment, we were told, "No its fine in there." This contradicted the risk assessment that was in place.

Care plans for people did not always reflect people's health needs. One person told us that they had epilepsy. However, their care plan did not contain any information around this. When we asked the staff member if there was a care plan around this condition we were told, "No, he doesn't have this condition." However, is MAR profile sheet confirmed that they were on medication to manage his epilepsy. This meant that staff would not always be aware of how a person's health need would affect the care they required. This was even more prominent for agency or new staff who had no background information or knowledge of this person.

During the inspection while talking to a staff member, we heard a person shouting loudly. The staff member looked out of the door but did not respond any further. We asked them if they needed to leave the room to check on people. They said, "No its okay, [one person] does it a lot." However, they did not check that any other people were involved and that the situation was safe. We had to ask them to check that the person calling out was safe. This demonstrated a complacent approach towards risk in the service.

Steps had not 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 be able 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. The service had an emergency policy, which described what steps to take in the event of fallen trees, flood, fire or snow and ice. However, it did not cover other emergency events such as what steps to take if the car transporting people broke down, if staff were unable to reach the service due to adverse weather, during a flu epidemic or in the case of a failure of services such as a gas leak. This meant that people would be at risk in some emergency situations.

The service did not complete accident and incident forms to learn lessons and improve where things had gone wrong. A staff member told us, "If something happens we have to record and report on the A&I form and give it to our manager. Then we have to speak about it in a meeting." However, this was not occurring. Accidents or incidents that had occurred where recorded in people's care plans rather than a central file where the evidence could be collated and analysed. 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.

People were cared for by staff who were aware of and carried out safe infection control processes. One staff member told us, "When we assist them we wear gloves and aprons." Another staff member said, "Yes we wear gloves and aprons. We never run out of them." However, safe infection control practices of the environment were not completed. We observed that cleaning equipment was left outside on the garden floor. The cupboard where hazardous cleaning materials were kept was also left open and was accessible to people during the inspection. This meant that people were at risk of harm.

Failure to follow risk assessments and analyse incidents to prevent them re-occurring was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not a sufficient number of staff to be able to meet people's needs. A relative said, "I think there is enough staff though. However, if [my family member] wants to go to out and the others don't want to then none of them go. They should have another staff member for that, even if it's only a couple of times a week." A staff member told us, "We lack staff at the moment. We need more staff during the day as if one person decides not to go out it means the rest can't go and they all have to stay at home. Sometimes they just want to go for a walk but they can't go."

Rotas showed that there was one member of staff working during the day, and another staff member for the night shift. However, one person required one to one support twice a week for activities and when people did go out two people required staff to monitor them to help keep them safe. The same person told us, "We can't go bowling today because you're here." However there would not have been enough staff to take people out as only one member of staff was working who would have been unable to support two people. The staff member on shift was expected to carry out household duties such as cleaning and laundry whilst supervising and caring for people the entire day. This left people with little interaction and they spent most of the inspection watching television. The staff member told us, "We're planning to get more staff when we get more people." Due to their only being one staff member per day it also meant that they were unable to supervise people throughout the day of the inspection to mitigate any risks that could have occurred.

Staffing rotas demonstrated that staff members were working long hours. For example, on one occasion one member of staff had worked for seven hours during the day and then completed a night shift at the provider'

other home. On another occasion, another member of staff had completed a night shift, then worked for two and a half hours at the provider's other home before returning to complete another night shift. This meant that staff were not receiving adequate breaks in between shifts at work.

The failure to effectively 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. To date, we have only received one full recruitment file, which did not include 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. One person informed us, "I don't like [a staff member], he pushes me in my room and hits me on my hand." The local authority had been made aware of this incident. We checked the service's safeguarding records but were told by staff these were not kept. From a review of behaviour charts recorded in people's care files we found that safeguarding incidents had occurred. However, these had not been reported to us or the local authority in line with stated safeguarding procedures. This left people at risk as concerns could not be appropriately investigated to ensure that people were safe from harm. Despite this information and the comments around safety referred to earlier in this domain, staff said that they were aware of safeguarding policies and procedures and how to report any concerns. One staff member told us, "First of all I need to inform my manager. Then I need to inform [the Care Quality Commission] and [the Multi Agency Safeguarding Hub]."

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's medicines were appropriately stored and managed. One person said, "I get my medicines when I need them." A relative told us, "[My family member] gets their pills on time." Medicine Administration Records (MARs) had no gaps and included important information such as any allergies and guidance around as and when medication (PRN). These also included a medicines definition and relevance sheet to explain to staff what each medicine is used for. People therefore received their medicines consistently and in a safe manner. Medicines that required specific storage and administration procedures were completed correctly.

Inadequate

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, "We don't impose our thoughts on them. We involve them in every decision." However, another staff member told us, "It's very difficult giving everyone choice. We will plan to go out with [one particular person] and they are aware of this. When you are ready they don't want to go. It destroys your day. If they don't go it ruins everyone's day as they can't go either." This meant that the other people who had capacity to decide that they still wanted to go out were not supported to achieve this. This meant that their rights were not being respected or listened to.

Decision specific mental capacity assessments were not completed. There was also no evidence that best interest meetings and decisions had taken place. Furthermore, DoLS had not been applied for where restrictions to people had been put in place. For example, the front door was constantly locked in order to stop people leaving the service at their own will. No mental capacity assessment, best interest decision or DoLS application had been completed for this. This meant people were being unlawfully deprived of their liberty.

The least restrictive option had not been considered where restrictions had been put in place. The door to the kitchen was locked throughout the day. A staff member said, "[People] come in and help themselves to stuff out of the fridge and [one person] turns the tap on and water splashes everywhere." Whilst there was access to a jug of water in the living room, people had to ask if they wanted a hot drink or snack during the day. This was overly restrictive. Staff said that they would look in to other options that were less restrictive to people.

These examples evidence a 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, "I suppose the staff are well trained, but I don't see them that often." Another relative told us "They definitely know what they are doing. The staff are absolutely amazing." A staff member told us, "We normally do training online. I did my own NVQ though. The company's training is helpful." Another staff member said, "Yes, we recently did a lone working course."

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, 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 left people at 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 received regular supervision. One staff member said "Every six months we have supervision. I find them helpful as that's when you can relay your stresses to the manager." We asked the manager to send us information in relation to the occurrence of staff supervisions and appraisals. 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 was mixed. One person said, "They cook what we want. I don't like the food though." Another person told us, "The food is okay." A relative said, "yes they help him maintain a healthy diet." Staff responded to people's dietary requests. A staff member told us, "We normally have a weekly meeting with them and we ask them what they would like on the menu." We observed that one resident asked for a cheese sandwich for lunch and this was made for them. 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. One relative said, "[My family member] was putting on weight but I spoke to the manager and they have now lost a couple of pounds." 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] sees the speech and language therapist and the doctor regularly. The physios are here if they need any help.' A staff member said, "We support people to get the appointments we need." We observed evidence of dentist, optician and GP involvement in people's care plans. However, recording of healthcare professionals input was incorrect. One person's activity checklist said that they had seen the dentist, optician, psychiatrist and the GP within three days. However, the person confirmed that this had not occurred when we spoke to them. Therefore, recording of healthcare appointments was not accurate.

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. However, it was not made to feel homely for people living at the service. There were three photograph collages on walls around the service, but these had not been updated. There was a lack of decoration to make the communal areas feel comfortable or homely.

There were effective communication processes in the service. A relative said, "They always contact me if anything has happened and let me know what's going on". One staff member told us, "We have a communication book and we handover book. The communication book is for what's happened during the day and the handover is to give the next staff member an instruction to do and to record what each SU has

done that day." Another staff member said, "We've got communication book for any messages we need to put across. Plus, we call the manager and they deal with it effectively." The communication book contained basic information on what people had done throughout the day. There was also an activity book which showed staff what they were expected to do during their shift, such as various cleaning jobs. These were ticked off throughout the day.

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.

Requires Improvement

Is the service caring?

Our findings

People, relatives and staff told us they felt that staff were respectful and caring. One person told us "The staff are caring". A relative said, "Yes they're definitely caring. [My family member] can be quite an awkward person and they're brilliant with them. A staff member told us, "We have a caring staffing team, because we sit down with them and laugh. I've never seen any staff abuse anyone."

Despite these comments, people were not always treated with kindness and respect. During the inspection, one person informed a staff member that they needed to go to the toilet and needed help. The staff member replied, "You're a liar, you don't need to go to the toilet." The staff member also referred to people as "this one", "that one", "the short one" and "the tall one" when speaking to us, rather than using people's names. Furthermore, the staff member repeatedly called a person by a name that was not their preferred choice. This showed a lack of respect to the person and their views. There was a lack of caring interactions from staff towards people. One person was trying to assist a staff member by passing them a teabag. The staff member sharply replied with "Put it back" rather than thanking them. At another point of the inspection, the staff member pointed to the sofa and said, "Sit down there now" to a person. This demonstrated a lack of respect or kindness towards people.

The privacy and dignity of people was not always respected by staff. One person's bathroom door did not have a lock on it, meaning that others would be able to walk in at any time. When we asked staff about this they had no explanation as to why it had not been fixed. One person had a broken door to his bedroom which had been removed. The provider had not found another method of maintaining this person's dignity in their bedroom, such as a screen. However, a staff member told us, "I go to their rooms to discuss private matters with them." Another staff member said, "When they are having a bath I make sure the door is closed."

Failure to provide dignified and respectful care was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to be independent where possible. A relative said, "[My family member] washes up and helps dust, hoover and cook." One staff member told us, "On Mondays I clean [a person's] room. They help me do everything. [People] normally assist us when we're cooking, [One person] loves making gravy and [another person] likes cutting onions." Another staff member said, "I allow them to do things like make a cup of tea. I just supervise them. They hoover too." However, we observed that the staff member made people's lunches and did not ask them to be involved and complete tasks they could do independently. The staff member said, "They choose what they want and we make it." This meant that people were not always 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, "I have been involved in reviews. I'm always invited and [my family member] is always included." Another relative said, "[My family member] is always involved in reviews and I always go every year. If I wanted an additional review I'm sure I

could arrange it." This meant that a holistic view of someone's care had been gathered. However, care files did not contain any details of reviews that people had been involved in the creation of their care plan. People were encouraged to make their own decisions around choices around their care. A staff member told us, "[One person] was always wearing jogging bottoms as his parents thought that this was all he would wear. However, we went out shopping and he choose jeans." This therefore gave people power to make decisions about their day to day life and care. People were able to personalise their rooms with their own furniture and personal items. One person said, "I like my room and my bathroom." Rooms felt individual to the person and allowed them to express their interests.

Inadequate

Is the service responsive?

Our findings

Care files were not person centred and 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. We found that staff did not know about people's care needs and were unable to tell us about any risks to them. Care plans contained information that was out of date. This included risk assessments and DoLS applications from 2015. This meant that staff were not always able to easily find information around people's current 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. A staff member said, "No we don't have those here." 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.

People were not always supported to attend activities that were meaningful to them. One person told us, "I go to the pub here that's nice." Two people also attended a local day centre on a regular basis throughout the week. However, one person required one to one support from staff to attend other activities twice a week. On the day of our inspection, the activity due for that day for that person was cancelled. The person told us "It's because you're here" in reference to our inspection. Their activity timetable showed that they were supported to go bowling or swimming twice a week, with the rest of the week showing tasks such as 'household chores' and 'listen to music'. Therefore, this person was not receiving personalised care in helping them attend activities that were meaningful to them.

Failure to provide person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were not responded to in line with the provider's policy. One relative told us, "I've had to complain now and then. I feel that I've got a satisfactory outcome to it. When I complained about something it took a while for them to do something but it eventually got sorted". A staff member told us, "I report any concerns to the manager or [deputy manager]. I follow up and make sure that people have been spoken to about it. We have complaints book but I put it in the communication book and the manager is supposed to put it in the complaints book."
The provider's complaints policy stated 'The manager must undertake any investigations and complete the Complaint Form Stage 1…. The outcome being recorded on the staff or customer's file.' A Quality Assurance Visit document from November 2018 stated that a complaint had been received and actioned and that the complainant was satisfied with the outcome. A staff member also informed us that they were also aware of two complaints the service had received in the past 18 months. However, the complaints and compliments log was blank, with pages ripped out at the front and back of the book. Therefore, complaints were not being appropriately recorded to ensure the appropriate steps were taken to reach an outcome.

Failure to act upon or acknowledge complaints received was 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

Relatives and staff told us they felt the registered manager was approachable and supportive. One relative said, "He is very approachable. I feel I can trust him". Another relative told us, "He is a gentleman, and [the deputy manager] is brilliant too. I can ring her anytime." One staff member said, "[The registered manager] is very approachable. Yes, I feel valued." Another staff member told us, "They're alright. They're trying their best even though we're short staffed. They're very approachable. I feel valued because every now and then they tell us how well we're doing and they appreciate our work."

However, effective management systems were not always in place to assess, monitor and improve the quality of service people received. The director of the service had completed three visits to the home in 2018 to check and record their quality around the premises and people's and staff's experiences at the service. The director had not identified the issues that we had found on the day of the inspection, 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 February 2018 stated, "I stressed upon staff the importance of proper supervision of residents while doing chores as it is part of the development of their skills, confidence and leading to independent living." 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. We found that people were still not being encouraged to be independent with these tasks, as people were not supported to make their own lunch. We did not see evidence of a recent medicines audit, with the last one occurring in January 2017 which found no issues. Therefore, the service would not be aware if there were any recent issues that they would need to rectify.

Records were not always accurate. Care files for people contained out of date information and were chaotic. 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 business continuity plans, accidents and incidents, safeguarding logs and complaints were not being completed. This could put people at risk.

The registered manager aimed to engage people, relatives and staff in the running of the service. A staff member said, "Staff meetings are usually every two months." Another staff member said, "We have regular staff meetings, around every three months. They're useful as we talk about changes to the people we care for, the environment, all sorts of things." However, we saw that there had been a gap of seven months between the last meetings. 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, in a staff meeting in December 2018 it is noted "We should keep our own staff rather than allowing them to leave" However, it did not state what possible actions to take were discussed from this point. Points from the previous meeting had not been reviewed, such as the TV in the lounge being broken. This meant that staff would not be aware of any updates from issues raised in previous meetings.

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 there had been altercations between people living at the service. We were also told by a person that a staff member had pushed them. These should have also been raised as safeguarding 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.

Relatives told us that they were asked for their feedback. One relative said, "I get a questionnaire to complete once a year. Somethings I can't answer as I don't live there. I feel any feedback I give is taken on board though." Another relative said, "I always fill in a questionnaire that they send once a year. Any feedback I give is taken on board but I don't give a lot as they are amazing with the people." Feedback gathered from relatives in the form of an annual survey was positive. One relative commented, "[My family member] has come on leaps and bounds. I am so happy he is in your care."

There were plans in place to expand the service. A staff member said, "We had an extension added to the home a year ago so we can take two new people." However, improvements could be aimed at improving the care for the people currently living at the service. 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, especially for the one person who didn't attend the day centre. 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 failed to make the Care Quality Commission of notifiable incidents and events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service failed to provide person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service failed to provide dignified and respectful care.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to notify the relevant authorities of safeguarding incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service failed to follow their complaints policy.

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 failed to ensure staff were employed safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to provide safe care and treatment.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to keep accurate records in relation to people's care and health needs, and records relating to the running of the service.

The enforcement action we took:

We served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to provide a sufficient number of staff to meet people's needs.

The enforcement action we took:

We served a warning notice.