# Rosecroft Care Limited

# Littlecroft

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 5 and 6 October 2016 and was unannounced. The previous inspection took place on 8 August 2014 and found there were no breaches in the legal requirements at that time.

Littlecroft provides accommodation and personal care for up to nine people who have learning disabilities. The service consists of two neighbouring chalet bungalows in a residential area.

There were eight people using the service at the time of our inspection who had a range of health and support needs. These included learning disabilities, very limited or nonverbal communication and some mobility difficulties. Some people had additional conditions such as epilepsy, autism and cerebral palsy. At the time of inspection four people lived in each bungalow. We met and spoke with each person. Most people were able to indicate to us they liked living in the services, they appeared happy, relaxed and contented in a comfortable living environment, interacting readily with staff and without hesitation.

This service had a registered manager in post. A registered manager is a person who is 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 also responsible for looking after other services owned by the same provider. Although always in contact with staff, when the registered manager was not present at the Littlecroft sites, team leaders oversaw the running of the service.

Our inspection found that whilst the service offered people a homely environment and their care needs were being supported; there were shortfalls in some areas that required improvement.

Personal emergency evacuation plans were not in place for people to inform staff about the support they would need to leave the service in the event of an emergency; fire drills had not been completed as required.

Maximum hot water temperatures, set by the Health and Safety Executive were marginally exceeded; although checks identified this, action had not been taken to rectify it.

Local authority safeguarding protocols require some events to be reported to them. The service did not have a copy of the protocols and had not recognised or reported an incident warranting this action.

When some 'as and when needed' medicines were administered, staff did not always record the quantity given.

Applications to meet the requirements of the Deprivation of Liberty Safeguards were not made when needed.

A quality monitoring system was in place, but was not effective enough to enable the service to highlight the

issues raised within this inspection.

Healthcare needs had been assessed and addressed. People had regular appointments with GPs, health and social care specialists, opticians, dentists, chiropodists and podiatrists to help them maintain their health and well-being.

Staff treated people with kindness and respect for their privacy and dignity. Staff knew people well and remembered the things that were important to them so that they received person-centred care.

People had been involved in their care planning and care plans recorded the ways in which they liked their support to be given. Bedrooms were personalised and people's preferences were respected.

Independence was encouraged so that people were able to help themselves as much as possible.

The provider had a set of values, which included treating everyone as an individual, working together as an inclusive team and respecting each other. Staff were aware of these and they were followed through into practice.

We found a number of breaches the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe

Plans needed to safely evacuate people in the event of emergencies were not in place.

Some hot water temperatures exceeded guidelines; action had not been taken to remedy this.

An incident warranting referral to the local safeguarding authority was not reported to them.

Medicines were safely managed, but we have made a recommendation to improve some records about the quantity given.

There were enough staff to safely support people; however some recruitment checks were incomplete.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Referrals had not been made to a supervisory body to meet the requirements of Deprivation of Liberty Safeguards.

Staff received appropriate instruction and training when they first started work; on-going training ensured staff had the skills and knowledge to support the people they cared for.

Staff were provided with opportunities to meet the managers to discuss their work performance, training and development.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

### Is the service caring?

**Good**

The service was caring.

Staff took the time needed to communicate with people and included people in conversations. Staff spoke with people in a caring, dignified and compassionate way.

Staff knew people well and knew how they preferred to be supported.

People's privacy and dignity was maintained and respected.

Staff supported people to maintain contact with their family where possible.

## Is the service responsive?

**Good**

The service was responsive.

People's care and support was planned in line with their individual care and support needs.

Staff had a good understanding of people's needs and preferences. People were supported to take part in activities that they chose.

There was a complaints system and people knew how to complain. Views from people and their relatives were taken into account and acted on.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

Quality assurance processes were not always effective to ensure required actions were identified and progressed.

Staff felt supported and there was an open culture in the home which encouraged staff and people to share their views.

Statutory notifications required by CQC were submitted when needed.

Staff were aware of their responsibilities to share any concerns about the service.

# Littlecroft

**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.

We undertook an unannounced inspection of this service on 5 and 6 October 2016. The inspection was undertaken by one inspector, this was because the service was small and it was considered that additional inspection staff could be intrusive to people's daily routine.

We reviewed a range of records. This included three care plans and associated risk information and environmental risk information. We looked at recruitment information for three staff, their training and supervision records in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and provider. We spoke with each person, three staff and the registered manager. Some people were not able to speak with us directly, to help us further understand their experiences; we observed their responses to the daily events going on around them, their interaction with each other and with staff.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and healthcare professionals. We reviewed notifications of incidents and other documentation that the provider had sent us since our last inspection. A notification is information about important events which the home is required to tell us about by law.

Requires Improvement

# Is the service safe?

## Our findings

People appeared comfortable with each other and staff and moved around the service and gardens as they wanted to. Where some people had conditions that caused seizures, sometimes making them drop to the floor, staff were on hand to ensure they were safely supported. Feedback provided in surveys by visitors, family members and health and social care professionals about the service was positive; it reflected they felt people were safe.

People were comfortable within their home environment and appeared reassured by staff who supported them. However, we found some concerns which meant the service was not always safe.

People would need help and assistance to leave the service in the event of an emergency evacuation. Individual personal emergency evacuation plans (PEEPs) to establish people's support needs during these circumstances were not in place. Additionally, the registered manager was unable to provide details or records of when fire drills had taken place. Staff were therefore not aware how people may respond to a fire alarm, the support they need to leave the service safely or practiced in evacuation procedures. This placed people at risk.

Hot water test checks were completed monthly. Records showed water temperatures recorded in one bungalow regularly exceeded the maximum temperatures set by the Health and Safety Executive, all be it marginally. Action had not been taken to adjust temperatures with requirements, although as a reference, maximum permitted temperatures were clearly shown on the completed paperwork. In the other bungalow, when pointed out to the registered manager, adjustments were immediately made to an unregulated hot water tap on the designated wash hand basin in the kitchen because the water was excessively hot. Although a water management plan was in place to reduce the risks of legionella, water borne bacteria, records were not maintained of shower head cleaning and the intervals of cleaning described by staff did not meet with the service's policy.

A lack of emergency evacuation plans and fire drills meant risks were not identified or reasonably mitigated. Unresolved excessive water temperatures potentially placed people at risk of scalding. This was a breach of Regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in safeguarding adults; they were able to describe different types of abuse and told us they knew the procedures to report any suspicions of abuse or allegations. There was a clear safeguarding and whistle blowing policy, However, records of incidents and accidents showed an occurrence where a person had sustained an injury caused by another person at the home. The local Kent and Medway safeguarding protocols categorise causing another person physical injury as abuse. The service did not have a reference copy of the local Kent and Medway safeguarding protocols. Staff and the registered manager had not recognised the need to report this incident to the local authority. This meant an incident, described as abuse within local authority protocols, was not investigated. This did not meet with the service's policy or established protocols.

People were not protected from the risk of abuse because systems had not been operated effectively to include referral to the appropriate body. This was in breach of Regulation 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

We read six staff recruitment files to make sure proper pre-employment enquiries had been made. All appropriate documentation had been completed, references and Disclosure Barring Checks (DBS) checks had been recorded. DBS checks establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Interview notes had been kept and these showed the service had made efforts to take on the best staff for the job. However, although resolved during the inspection, some identity checks required had not been completed. This did not present a fully embedded recruitment method or compliment robust recruitment procedures.

The service had not fully applied established recruitment systems to ensure all processes were embedded into practice. Records held did not meet with requirement of Schedule 3 of the Regulations. This was a breach of Regulation 19 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

Administration of medicines was undertaken appropriately. Staff were patient and knowledgeable, they reminded people what the medicines was and explained if pills were to be chewed or swallowed with a drink. Opened medicines were dated to ensure they were not used beyond their shelf life. Where skin creams were used, charts recorded its application and guidance ensured staff knew where, how much and when the cream should be applied. Refusal of medicine was recorded and contact made with relevant health professionals if this continued. No medicines were given to people without their knowledge; where medicines were given with food to make them more palatable or easier to swallow, checks with the pharmacist ensured this did not alter the properties of the medicine. Staff knew how to give rescue medication for conditions such as epilepsy.

Medicine administration records (MAR) included a photograph of the person, what medicines were prescribed, what they were for and details of any possible side effects. MAR charts were completed as required. Weekly checks of medicines took place and records showed the amounts stored were correct. Any medicines no longer needed were accounted for and returned to the pharmacy for safe disposal. Protocols were in place for 'as and when required medicines' (PRN) medicines, such as paracetamol and laxatives. Staff were knowledgeable about when they might be needed and how to monitor people's conditions to help them interpret people's need for them.

We identified an issue and bought it to the attention of the service. There was some inconsistency in the completion of MAR charts for PRN medicines. Although its administration and time given was always recorded each time, only some staff recorded the quantity given. This did not meet with established practice.

We recommend the service review and adopt PRN medication administration and recording practices ensuring they conform with and reflect best practice in published guidance, such as, the Royal Pharmaceutical Society for The Handling of Medicines in Social Care or The National Institute for Health and Care Excellence (NICE) Managing Medicines in Care Homes.

Staffing levels were based upon people's dependency assessments and were flexible to accommodate outings, activities and accompanying people to appointments. Staffing comprised of two staff on the day shift and one sleep night member of staff per bungalow. This had been recently reviewed and a decision made to change to a wake night member of staff in one bungalow because of a person's evident need. There

was an established on call system should additional support be required. Agency staff were not used, any shortfall was met by staff employed by the provider. This ensured familiarity of people's needs and enabled them to be addressed consistently and safely. People and staff felt there were enough staff on duty to support people, their activities and safety.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. Staff knew the different risks associated with each person and how to minimise any occurrence. Risk assessments were in place to help keep people safe in the service and when outside or attending activities. They clearly set out the type and level of risk as well as measures taken to reduce risk. These enabled people to be as independent as possible. For example, they included safety in public places, using transport, epilepsy seizures and rescue medicines needed. This helped to ensure that people were encouraged to live their lives whilst supported safely and consistently.

Risk assessments were reviewed when needed and linked to accident and incident reporting processes. Accidents and incidents were comparatively low in frequency and managed in a way which protected people from the likelihood of recurrences. Staff had completed incident reports and the registered manager recorded their actions. This helped to ensure the service learned from incidents and put processes in place to reduce the risk of them happening again.

Records showed the provider ensured proper checks were carried out of the electrical installation in the bungalows; the gas safety certificates were current and portable electrical appliances checked. Fire extinguishers were checked and emergency lighting regularly tested. The service had a formal strategy to ensure people received safe and continuous care in case of emergencies at sister services owned by the same provider.

Requires Improvement

# Is the service effective?

## Our findings

Views provided by relatives and social and health care professionals in surveys reflected that staff knew people well and understood how to communicate effectively according to individual needs. People were unguarded, reacting openly and positively when supported by staff. Some people led staff to show how they wanted to be supported or what they wanted to do; other people communicated by facial expression, behaviour, mannerism, making sounds, gesturing or with a few words. Staff understood people's communication and provided informed and wholehearted support. Although people were positive, we found an aspect of the service meant it was not always effective.

Staff had received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS form part of the MCA and aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used. Restrictions could include, for example, bed rails, lap belts, restrictions about leaving the service and constant supervision inside and outside of the service.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Each person living at the service needed to be supervised if outside of the service, which is considered a restriction on their movements. An application and authorisation had been made and granted for one person; however, this was about specific restrictions within the service that were no longer needed. It was a three month authorisation, which had subsequently expired. Capacity assessments were not in place for people to determine if they were able to consent to receive care and support at the service. Applications had not been made to the local authority for DoLS authorisations and mental capacity assessments or best interest meetings had not been completed to determine people's capacity or agreement to live at the service.

A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This is a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In terms of day to day living and decisions, staff gained people's consent to give them care and support and carried this out in line with their wishes. People were involved in their day to day choices about accessing activities, spending time outside of the service, the food and drinks they had and their daily routines. Some people indicated choice by pushing away unwanted items or by leading staff to show what they wanted, hand gestures and limited verbal communication. In addition some people were able to supplement their communication with Makaton hand signs, which staff recognised and responded to. Referrals were made to speech and language therapists to help with communication difficulties. One person had recently received a computer tablet to support their communication needs.

Policies reflected if people lacked capacity where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate or

Relevant Person Representative was required. These are workers who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service and best interest processes had been used in relation to dental work.

People had individual communication plans together with cues to help staff identify distress signs in people who, because of cognitive impairment or physical illness, had severely limited communication. This included information about facial expressions, body language and gestures as well as other indicators such as people's general demeanour and what any changes may indicate. For example, how people may appear and react if they experienced pain, anxiety or were becoming frustrated. These helped to ensure effective understanding between people and staff and helped staff to recognise if people were unable to communicate their needs.

Staff were aware of people's food preferences and any specific dietary needs. Some people went to local shops and chose what they wanted to eat. People were aware of the benefits of healthy eating and where some people needed support to lose weight, they had achieved this. There was a good choice of food; meals were varied and enjoyed. Where people had difficulties swallowing or this presented a choking risk, Speech and Language Therapist advice was sought and put into practice. Staff carefully prepared meals and drinks to required consistencies and helped those who required support to eat and drink.

People were supported to maintain good health and received ongoing healthcare. They were registered with the local GP and had access to other health care services and professionals as required. Where specialist advice was needed, for example about people's mental health, communication or physical difficulties, we found referrals had taken place and the advice received was followed. Health action plans were based upon individual needs and included dates for medical appointments, medicine reviews and annual health checks; these had taken place when needed. Where people presented behaviour that could challenge staff or others, staff worked with health professionals to look at ways of managing the behaviour. Interventions and restraint were not used; other techniques and strategies, such as positive behaviour support and positive reinforcement strategies were used.

A training planner identified when training was due and when it should be refreshed. Staff received regular training in areas essential to the effective running of the service such as fire safety, first aid, infection control and food hygiene. Additional training had been delivered which helped staff support people, including epilepsy awareness as well as specific training for administration of epilepsy recovery medicines. Training provided was a mixture of computer based learning and face to face training. Staff told us the training was good quality and they felt confident to do their job properly.

Written supervisions had lapsed for some staff. Discussions with the registered manager found competing priorities had meant they had spent time supporting people and had not been able to complete all written formal supervisions. Informal supervisions had taken place; staff told us they felt supported by the manager and had opportunities to discuss any concerns. Current commitments meant the manager was able to reinstate the supervision schedule. Recent written supervisions and appraisals confirmed this was the case.

A comprehensive induction programme and ongoing training ensured staff had the skills and knowledge needed to effectively meet people's needs. The provider subscribed to and used the Skills For Care Certificate, an identified set of standards that social care workers adhere to in their daily working life for the induction of new staff following the successful completion of probationary periods. All staff had achieved or worked towards NVQ or Care Diplomas levels two and three.

Staff communication was effective. A handover book ensured key information was passed between staff, such as GP appointments and key comments about care and support delivered. Staff told us this system worked well.

Good

# Is the service caring?

## Our findings

There was a pleasant atmosphere in the service, some people laughed and smiled as staff supported them; one person bought staff a toy telephone who used it to speak to them. Another person enjoyed the sound a book cover made that staff had laminated for them. This provided visible enjoyment and reassurance for people.

Staff made time to listen to people; they were intuitive in their support, responding to individual communication cues compassionately and always with respect. Staff were considerate and courteous when supporting the people in their care. They were friendly and unhurried in their approach, giving people time to process information and communicate their responses.

There was a strong and visible person centred culture at the service. Care was planned around the individual and centred on the person. Staff knew about people's background, their preferences, likes and dislikes. Staff spent time with people to get to know them. There were descriptions of what was important to people and how to care for them in their care plan. One member of staff told us, "We get to know people by working with them and building trust and relationships with people and their families". They recognised where possible the importance of working well with families.

Staff were attentive. They observed and listened to what people were expressing. Pictures and photos were used to help people to make choices and communicate what they wanted. People responded well to staff and we saw staff interacting with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner.

Staff were able to describe each person's support needs accurately and tell us about them as an individual and describe people's individual personalities. Records of people's days had been made and provided information about the support and care they had received, together with some photographs of what they had been doing.

Staff were aware that different people responded to different styles of support, they were consistent in the ways they supported people. For example, short sentences helped some people understand what to do, where as other people led staff to help support them with tasks; staff were always mindful of people's independence and gave them the chance to do things for themselves before stepping in or prompting if needed. Care plans included guidance for staff to support people to do as many things for themselves as they could; we observed this happening during the inspection. For example, when people were eating or putting on shoes.

When people were at the service they could choose whether they wanted to spend time in communal areas or time in the privacy of their bedrooms. People could have visitors when they wanted. People were supported to have as much contact with family and friends as they wanted to. People were supported to go and visit their families, relatives and friends. During the inspection it was evident that families continued to play a large part in people's lives.

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. People were given support with washing and dressing if needed. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their communication needs.

People's privacy was respected. People were moving freely around the home, moving between their own private space and communal areas at ease. Staff knocked on people's doors before entering. Doors were closed when people were in bathrooms and toilets. People were given discrete support with their personal care.

Some people expressed their anxieties and frustrations in behaviour that could challenge others or pose a risk to them. Staff had received training which followed a positive behaviour support model and focussed on proactive methods to avoid triggers that may lead to a person to present behavioural challenges. The aims were to support staff to identify triggers and recognise early behavioural indicators, so that non-physical interventions could be used to prevent a crisis from occurring.

Staff felt the care and support provided was person centred and individual to each person. Staff had built up relationships with people and were familiar with their life stories and preferences. People's care plans told us how their religious needs would be met if they indicated they wished to practice. People's information was kept securely and staff were aware of the need for confidentiality.

Good

# Is the service responsive?

## Our findings

When a person moved into the service an assessment was completed. When people needed support to communicate their needs other people advocated on their behalf, for example, members of their family or someone who knew them well. People were enabled to contribute as much for themselves as possible.

Information was gathered about people's interests and about what was important to them. Staff were able to demonstrate a good understanding of the people they supported. Within people's plans were life histories, detailed guidance on communication and personal risk assessments. In addition there was specific guidance describing how the staff should support people with various needs, including what they could and could not do for themselves, what they needed help with and how to support them.

Some people had specific behavioural needs and these were well documented in their care plan. Staff showed that they were very clear about these needs and how to support them. Some people were able to say what they wanted, and staff were responsive to people if they became unsettled or unhappy about something. Staff told us care plans gave an in-depth understanding of the person and were personalised to help staff to support the person in the way that they liked.

Care plans contained information about people's individuality which was presented in a person-centred way. Care plans contained information about people's wishes and preferences and detailed guidance on people's likes and dislikes around food, drinks, activities and situations. Challenging behaviour care plans detailed what people may do, why they did it, warning signs and triggers and how best to support them.

Health action plans were also in place detailing people's health care needs and involvement of any health care professionals. Each person had a healthcare summary, which would give healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were kept up to date and reflected the care and support given to people during the inspection. People had review meetings to discuss their care and support. They invited care managers, family and staff.

Health plans contained comprehensive and specific information. This had helped to ensure specific conditions were monitored and appropriately reviewed so that the right support was provided. Specialist occupational aids were provided, for example, profiling beds and where needed epilepsy bed monitors ensured people were safe when they slept and individually designed orthopaedic wheels chairs, shoes and shoe inserts supported people with their mobility. Where people needed head protection to minimise risk of injury, this was always used, well fitted and in good condition.

Where people had specific conditions, for example, epilepsy, there was guidance for staff about symptoms or indicators which may precede a seizure and the support the person would need. Monitoring of seizures helped to inform medication reviews and to determine how well the epilepsy was managed. Health care needs were clearly recorded and contained comprehensive and specific information, including input from health and social care specialists where necessary. This had helped to ensure that health conditions were

monitored and appropriately reviewed.

People enjoyed various activities, both inside and outside of the service, these included, music, garden games, walks and outings. Some people attended an activity centre and two vehicles based at the service enabled staff to drive people to their various activities. People were supported to participate in activities of their choice, within the service and the community. We were told about past and upcoming events held at the service and sister services.

The service's complaints procedure was available in pictorial form; it was clear and included both verbal and written complaints. There were no complaints at the time of our inspection. Staff clearly explained how they would support people to make a complaint if the need arose. In a recent survey, a relative had commented they appreciated all hard work of the staff in supporting their relative.

Requires Improvement

# Is the service well-led?

## Our findings

The service had a registered manager who was supported by team leaders and support workers. They had recently been registered by the Commission as manager of this service but also worked as the registered manager at sister services. The registered manager explained that they split their time equally between the services they managed, although if one service needed more input at a particular time, they would spend more time there. Staff and people were positive about the registered manager, describing them as always approachable and supportive. Staff felt the provider and registered manager listened to their opinions and took their views into account, giving examples of food quality and support needs.

The registered manager and provider undertook regular checks of the home to make sure it was safe and remained serviceable. Environmental risk assessments were reviewed and up to date. However, checks had not identified that personal emergency evacuation plans were not in place or that fire drills were not carried out or recorded as required. An unregulated hot water tap and uncorrected marginally excessive water temperature readings presented potential for scalding; some recruitment processes were incomplete. In addition, safeguarding incidents warranting notification to the local authority had not been made and the service had not recognised the need to consider DoLS applications for most people at the service. The concerns identified illustrated that the quality assurance measures currently in place were not fully effective.

This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Established systems sought the views of people, relatives, staff and health and social care professionals and had been undertaken for the current year. Questions covered areas such as staffing, choices, feeling safe and being listened to, and the responses were positive overall. The service had a variety of methods by which to measure the standard of care and people's experiences of it, including one to one meetings and discussions with people's families.

The registered manager and all staff demonstrated a good knowledge of people's needs and spoke with passion when talking to us about supporting people. During the inspection we observed that people engaged well with the registered manager who was open and approachable. Staff had delegated responsibility for health and safety, doing daily allocated jobs and attending training courses. They were clear about their role and responsibilities and were confident throughout the inspection.

The registered manager made sure that staff were kept informed about people's care needs and about any other issues. Staff handovers and team meetings were used to update staff regularly on people's changing needs. There were a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed. There was a positive and open culture between people, staff and management. Through our observations at inspection it was clear that there was a good team work ethic and that staff felt committed to providing a

good quality of life to people.

The visions and values of the organisation were putting people first, being a family, acting with integrity, being positive and striving for excellence, the registered manager and staff were clear about the aims and visions of the service. People were at the centre of the service and everything revolved around their needs and what they wanted. When staff spoke about people, they were clear about putting people first.

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. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way and had done so.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 11 (1)(2)(3). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not ensured emergency evacuation plans were in place to ensure risks reasonably mitigated, fire drills had not taken place as needed and unresolved excessive water temperatures potentially placed people at risk of scalding. Regulation 12 (1)(2)(a)(b)(d) |

| 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<br><br>The provider had not ensured people were protected from abuse and improper treatment because systems and processes must be established and operated effectively to prevent abuse of service users. Regulation 13 (1)(2)(3)(6)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |

| | |
|---|---|
| | The provider had failed to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services. Regulation 17 (1)(2)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had not fully applied established recruitment systems to ensure all required processes were embedded into practice. Regulation 19 (1)(2)(3)(a) |