Tracs Limited

Maycroft

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 and 16 March 2017and was unannounced. We last inspected this service in July 2014 and we found the registered provider was meeting people's needs and the requirements of the law at this time.

Maycroft is a care home for up to six people with learning disabilities or autism. There were five people living at the home at the time of our inspection. There was a registered manager in place who had worked at the home for several years. 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.

People were not always supported to feel safe at the service. Risk management at the home failed to promote people's independence and safety. Staff were due to receive refresher safeguarding training to ensure that they remained aware of their responsibilities to protect people. We observed that there were enough staff to meet people's needs and saw that staff had been recruited following the registered provider's suitable recruitment processes. People were often supported through safe medicines management, although further areas of improvement were identified.

People did not experience a consistent approach from staff which was informed through effective, person-centred care planning. People were supported by staff who received relevant training for their roles and who were kept informed of plans and changes at the home during handover sessions. The same team of staff had supported people over a long period of time at the home and we saw that they were familiar with people. People were not supported in line with the Mental Capacity Act (2005) and staff did not always support people to express or make their own decisions.

People had been referred to community health teams and for additional support on occasions during their time at the home. We could not be confident however that healthcare guidance was always sought and recommendations followed to promote people's health over time.

People were not always addressed and supported by staff in a way that was respectful and promoted their dignity. People were not always encouraged to make decisions about their care and day-to-day routines. People's care records did not always demonstrated a person-centred approach which met their needs. Relatives told us that they were involved in regular care plan reviews.

There was a registered manager in place who had not identified concerns relating to the culture of the service including where people were not supported to become involved in their care and the approach of some staff. Records were not always robust, and systems were not effective for ensuring the quality and safety of the service despite the registered provider's active role in overseeing aspects of the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's risks were not always managed effectively to promote their safety and independence as far as possible.

People were supported by sufficient numbers of staff who had been recruited following suitable checks before they commenced work.

People were supported to take their medicines safely, although further improvement was required in this area.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported to make their own choices and to receive care in line with the principles of the Mental Capacity Act (2005).

People's needs were not always met. Staff received relevant training for their roles however people's care was not planned to meet their needs or good practice guidelines.

People were supported to seek healthcare support when they were unwell, although we could not be confident that healthcare guidance was routinely referred to and action taken to promote people's health over time.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently treated with dignity and respect.

People's privacy was not promoted and people were not routinely involved in day-to-day decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans did not reflect their full and up-to-date needs and wishes.

Relatives could complain through the registered provider's formal complaints process, although this process was not made accessible to people living at the home.

Is the service well-led?

Requires Improvement

The service was not well-led.

The service did not always promote a person-centred, inclusive culture. Systems were not effective for ensuring the quality and safety of the service and to drive improvement. Records were not always robust.

Maycroft

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.

This inspection took place on 15 and 16 March 2017 and was unannounced. The inspection was conducted by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection, we looked at the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding incidents. We also referred to a previous Provider Information Return (PIR) that had been submitted by the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this to help plan aspects of our inspection.

Most people living at the home were not able to speak with us and provide verbal feedback due to their support needs. We carried out observations of how people were supported throughout the day and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. During our visit, we also looked at two people's care records, three staff files and at records maintained by the home about care planning, staff training and other documents relating to the quality and safety of the service. As part of our inspection we also spoke with one healthcare professional, two relatives of people living at the home, three staff members and the registered manager.

Requires Improvement

Is the service safe?

Our findings

Support provided to help people to manage their risks at the home was not always appropriate and failed to promote people's independence as far as possible. Although staff we spoke with were aware of care plans that were in place to manage some people's risks, this planned support did not ensure that people's needs were met nor did they enable people to safely enjoy greater freedom at the home. The registered manager and all staff we spoke with described a historic risk in respect of one person living at the home and confirmed that this risk was no longer significant. Despite this, people were moved to other parts of the home and monitored closely by staff as actions that were deemed to have mitigated the potential impact of this risk in the past. We found that these actions were continuing to be followed by staff although their relevance and this person's specific needs had not been reviewed and monitored effectively over a long period of time. Incidents involving this person at the home were not always monitored and investigated as required by the registered provider and failed to promote the safety and positive experience of people living at the home.

Some people living at the home had specific risks whereby they had access to several objects within the home environment which they were at risk of using to cause harm to themselves or others. For some people, the registered manager had not considered less restrictive practice to protect people from the risks associated with objects, to allow people greater liberty within the home. Conversely, in respect of another person who was at risk of self-injury, staff did not follow planned actions which would help to minimise the risk of harm to this person. We observed that the person was therefore able to cause further harm through injury during our visit. We asked a staff member about this person's needs who told us, "I don't really know the procedures [for minimising this risk]." This staff member told us that the person's medicine, "Takes the edge off self-harm." Action to help mitigate and manage risks to people in a way that promoted their independence and safety as far as possible at the home was not done.

Failure to provide care that balances the needs and safety of people using the service with their rights and preferences, and in accordance with the Mental Capacity Act (2005), is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us that one person was, "Very safe," living at the home. Our discussions with relatives of people living at the home showed that they felt confident that no individual staff would harm their relative and that the home environment was a safe place to live. Steps were not always taken to ensure people felt safe and that people were aware of how to share any worries or concerns they may have; the registered manager did not follow good practice in ensuring that safeguarding guidance was accessible to people living at the home and visitors to raise awareness of safeguarding vulnerable adults from abuse. Staff had received safeguarding training and the registered provider had identified that staff required refresher training in this area to ensure staff remained aware of how to identify and report any concerns. Staff we spoke with understood their responsibilities to protect people living at the home and told us that they would inform the registered manager of any concerns they identified. One staff member we spoke with told us that they had previously done so and commented, "If I don't say anything [about the concerns], I'm just as bad." Another staff member demonstrated a clear awareness of risks at the home and told us that risk

assessments were updated regularly.

Staff we spoke with showed awareness of people's risks and needs although care records we sampled did not provide comprehensive information as to how staff should support people accordingly and in line with good practice guidelines. Staff told us that one person had received community health support previously as they had developed sore skin. A staff member explained how another person was receiving such support and using creams to help manage this risk, although there were no records to reflect this and how the person's skin condition progressed over time. Other regular monitoring checks were in place however, including equipment checks, weight monitoring and risks associated with people's healthcare conditions, to help promote people's safety.

Annual fire safety checks of the home were conducted and staff we spoke with told us that they undertook regular fire safety drills with people living at the home so that they would be familiar with how to respond in the event of a fire. Good practice was not always followed as planned by the registered provider to ensure the safety of the home. We observed that the kitchen fire door was propped open which would prevent safety in the event of a fire and the security of key cabinets and medicines storage at the home were not always maintained. Health and safety checks were not robust. Checks had failed to address that parts of the environment were cluttered and inaccessible to people living at the home. One person's equipment in their bedroom was not fitted safely, this had not been identified through health and safety checks. We also observed that one person's wheelchair brakes were not always applied before they were supported to sit in their wheelchair and on occasions after people were moved around the home in their wheelchairs. People's equipment was not always used safely. Staff had received infection control training. One staff member told us that they felt supported and equipped in this area, although another staff member we spoke with did not demonstrate confidence in maintaining safe infection control at the home.

We saw that there were enough staff deployed at the home and people received support from the correct number of staff as planned. The registered manager told us that people were sometimes supported by bank staff who were employed by the registered provider and who were familiar with the home. People were protected by safe recruitment practices which included checks for criminal history and ensured that staff were suitable.

People were mostly supported safely through medicines practice at the home. A senior staff member who took a lead role in this area demonstrated a clear understanding of the support people needed with their medicines. This staff member provided staff with medicines training and undertook staff competency assessments to ensure that people were supported safely with their medicines. The senior staff member told us that they were supporting other staff to develop these skills to achieve a high, consistent level of safe practice at the home. Staff practice while administering medicines was not always safe or in line with good practice guidance however. On one occasion we observed that the staff member handling people's medicines engaged in another activity whilst doing so. Evidence shows this increases the risk of medicine errors. We saw that staff discussed one person's medicines support in a way that did not promote this person's privacy and dignity. People's medicines were stored in a dedicated locked room at the home, however medicines cabinets within this room were not always kept secure. Records we sampled showed that people had the correct amount of medicines in storage.

Audits were regularly conducted to ensure that people received most of their medicines safely. Some people required 'as and when' or PRN medicines for specific symptoms they experienced, guidance was available to inform staff when people required these medicines and alternative support to consider before providing people with this medicine. Some people living at the home used prescribed creams to minimise their risk of developing sore skin. Staff we spoke with confirmed that they supported people to apply these creams.

Records were in place to support this practice and our discussions with the senior staff member responsible for medicines management at the home showed that they recognised how these records could be improved to meet current good practice guidelines and ensure safe and consistent support for people living at the home. The registered provider assured us that this action would be taken.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People were subject to additional restrictions beyond these authorisations which did not adhere to the principles of the MCA. People were subject to ongoing monitoring throughout the day by staff and most people's bedrooms and many communal areas of the home were locked and accessible by staff only. Alternative and less restrictive means of keeping people safe had not been considered. Although MCA training had been provided to staff, such guidance did not translate into routine practice at the home and people were not often supported to make their own decisions and choices.

We observed a number of occasions where staff selected and changed television programmes for people to watch, without consulting people about this choice or anything else they would like to do or watch on television. We observed that two staff members changed the plans together as to where two people would go out into the community, this decision was not discussed with either person. We observed several occasions where people received support to move around the home and to undergo tasks without staff having sought their consent and without staff talking to people about what was happening. People were not consistently supported to become involved in their daily care and routines wherever possible.

People were not consistently supported by staff whose practice was informed by good practice guidelines and effective care planning. Although we observed that staff felt comfortable in their roles and staff told us they felt equipped for their roles, we found that people were not always supported appropriately and in a way that reflected consideration for their needs and preferences. People received care that was based on staff knowledge after staff had learned about people's needs over the time that they had supported them. Records we sampled had not been updated to inform consistent practice in line with people's needs. The registered manager and staff used inappropriate terminology to describe the behaviours of one person living at the home, this did not reflect a clear insight or understanding of this person's needs within the staff group.

Most staff we spoke with told us that they found the training helpful and all staff we spoke with told us that they felt equipped for their roles. One staff member told us, "The training is spot on, the overall home runs well." The registered manager confirmed that staff received an induction over three days when they joined the home and that new staff were supported to complete the Care Certificate. The Care Certificate is a set of minimum care standards that new care staff must cover as part of their induction process. Staff were

supported to receive refresher training in relevant areas such as moving and handling, safeguarding, medicines management and fire safety. Where staff training was overdue in some areas, this had been identified and continued to be monitored by the registered provider.

A relative told us, "The staff do look after [my relative]." Another relative told us that they were kept informed where appropriate about changes to their relative's support needs. Many staff members had worked at the home for several years and told us that they were familiar with the support needs of people living at the home. We observed that staff received clear information through handovers as to changes at the home and people's support needs. Staff we spoke with told us that they received supervision and appraisals to aid their development in their roles, although the registered manager told us that they did not conduct observed practice of staff to ensure that they provided safe and appropriate care. People did not receive care that was based on best practice, although staff had received guidance to carry out their roles and responsibilities.

People could not be confident that they would always receive appropriate nutritional support in line with their needs. People's care planning in respect of nutritional needs were not effective, one person's care plan we sampled provided outdated specific guidance about additional nutritional support that this person needed. Staff we spoke with told us that the person no longer required this additional support and described other ways that they supported this person with their meals. There was no guidance from healthcare professionals to confirm this decision and the person's care plan did not clearly guide staff as to all of this person's current risks and dietary requirements.

People's food and fluid intake was monitored by staff and we saw that people were supported to eat fresh, healthy meals. Our discussions with staff showed that they were aware of changes to people's weights over time. We observed that some people living at the home were supported to make breakfast with staff and one person was supported to eat at a time of day that suited them. Staff we spoke with told us that they supported some people to make choices by showing them various meal options, although our observations of people's mealtimes did not confirm this. We did not see this technique in practice or any use of other means to help people choose their meals. Our discussion with a relative showed that staff had not always considered this person's own food preferences when encouraging them to eat. A staff member we spoke with told us that meals that made by some staff did not always reflect people's dietary requirements and that alternative options had to be made when people chose not to eat these foods.

The registered provider monitored the frequency of people's access to healthcare support through quality assurance checks, which had identified occasions where record keeping in this area had required improvement. One person had been supported to access healthcare support on the day of our inspection as they were unwell. We found however in this instance that staff did not follow all recommended actions that had been previously advised and were detailed in the person's care plan to help promote their recovery.

A quality assurance check in December 2016 showed that staff had discussed how they identified and addressed signs that a person was feeling unwell. A relative we spoke with told us that people were supported to access healthcare support when they were unwell. Staff we spoke with told us that a person had been referred for an assessment for new equipment to ensure this remained suitable and comfortable.

People had been referred to community health teams and support on occasions during their time at the home to help promote their health and independence. Following our sample of records and discussions with the registered manager and staff, we could not be confident however that healthcare guidance was routinely referred to and action taken to monitor and promote people's health over time.

Requires Improvement

Is the service caring?

Our findings

Throughout our visit we observed, heard and read about interactions where people's dignity and respect had been compromised or not upheld by the actions of staff, or by the operation of the home. The registered manager and staff failed to consistently use appropriate language when referring to people and describing how they supported people living at the home. Staff did not adopt a discrete, respectful approach whilst supporting people at the home. Staff used terms of endearment when referring to people living at the home, such as referring to groups of people by their gender or using shortened versions of one person's name. We queried this with the registered manager and whether one person was happy to be addressed in this way, the registered manager confirmed that they did not know whether this was the person's preferred term of address. We observed an occasion when a staff member made derogatory comments about one person living at the home. The comments were directed towards this person and in the presence of others living at the home. This did not respect the person or reflect a positive caring relationship. The matter was raised as a safeguarding issue by the registered provider to promote the safety and dignity of people living at the home.

Four people living at the home were described by the registered manager as not able to express their needs and wishes verbally. People were not supported to express their views and wishes in line with their needs. A relative we spoke with told us that they were trying to help staff to understand how their relative will express themselves, although this person had lived at the home for a number of years. Staff often failed to communicate with people in a way that reflected their needs and preferences and to identify where people gave social cues and indicators to express themselves. We observed an occasion where one person who could not express their wishes verbally, struggled to access items of interest in the living room. The person gestured that they were experiencing difficulty in accessing the items and looked to staff on two occasions for assistance. Staff did not respond in a timely way to support this person. Staff we spoke with provided examples of how some people living at the home expressed their needs and wishes through other forms of communication. One staff member told us, "It's a lot of guesswork but we get there." Another staff member told us, "You go on what you think they're expressing." We found that other staff however did not consistently demonstrate such awareness and did not always empower people to express themselves. Care records we sampled showed that some guidance was available in respect of people's communication needs, however we observed this had not been utilised, and no consistent approach to communication was applied in practice. A staff member told us that this was a method of communication trialled previously at the home yet not continued with.

Staff did not often take opportunities to engage people in their day-to-day activities and to communicate with people about the support they required. We observed that people were often supported to move around the home without staff having sought their consent or staff informing people that they needed to support them to move. We observed occasions where two staff members supported people with routine tasks without engaging people or talking to them. People were not often involved in their care or supported at a pace that met their needs. This practice did not promote people's independence. A staff member we spoke with told us, "Sometimes you can become complacent and it can surprise you, for example [person eating independently]. They can hold a brush or the laundry basket." However, we did find that some staff

gave greater consideration to supporting people at their own pace and in a way that people enjoyed. We observed an occasion where a staff member and the registered manager spent time with one person living at the home to use sensory tools which the person enjoyed.

People's privacy was not respected or promoted. We observed that staff routinely discussed people's support needs in communal areas and in the presence of the person and others living at the home. Staff did not hold such discussions with discretion and we observed occasions where staff called out to other members of staff in other areas of home about people's support needs or updates. Where one person had caused harm to themselves, staff discussed this incident and the person's needs in the presence of the person and without sensitivity or involving the person in this discussion. Staff gave no consideration as to the impact this discussion may have on this person.

We observed that people's private care files and documentation were left around the communal areas of the home and were accessible to others. The registered manager confirmed that this was typical practice, this did not respect people's confidentiality.

Where two people were supported to get ready to go into the community, they were not supported at a pace that met their needs or involved in this task by staff. Staff did not communicate with the two people about how they were being supported or seek their consent in relation to the support provided. One staff member made attempts to help one person's clothing to fit appropriately in a way that did not promote the person's dignity. We questioned this with the staff member and the registered manager who confirmed that this person had alternative, better fitting clothes available at the home. The staff member had failed to make this person more comfortable and ensure that they were presented in a way that promoted their dignity.

Failure to provide people receiving care and treatment with dignity and respect at all times is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with provided examples of how they promoted people's privacy and dignity in practice and we observed some isolated examples of this in practice. One staff member told us, "I think everyone cares for people here." Another staff member commented, "All staff care, and show it." A relative told us, "There's no doubt that [staff] think the world of [my relative]." Some staff we spoke with demonstrated care and affection for the people they supported. One staff member told us, "They are like an extended part of your family… I have a good working relationship with all [people living at the home]," and provided examples of this in practice. The registered manager told us that they arranged celebrations at the home for special occasions including festive periods.

Requires Improvement

Is the service responsive?

Our findings

People living at the home were not consistently supported to use equipment and resources that were tailored to their needs. There was a sensory room available at the home although we saw that this was not fit for its planned purpose. One staff member told us that this part of the home was not used as a sensory room and had already been identified as another television room. The staff member commented, "It's alright when it's done, there is clutter and storage in the corner… it needs tidying." The registered manager confirmed that there was excess storage of surplus items in this room and told us that the television had been added to this room to offer people the choice to watch television. This did not strive to meet the purpose or benefit of sensory stimulation for people living at the home or meet current good practice guidelines. One staff member described how previous interactive activities that people had benefitted from were no longer held at the home although there had been no specific reason for ceasing this practice.

People had regular care reviews and relatives we spoke with told us that they were involved in these. The registered manager provided us with an example of one person's care plan review which detailed various aspects of the person's care and progress during their time living at the home. Although the registered manager confirmed that care reviews were undertaken every six months, care plans we sampled did not provide full and accurate details of people's support needs, the discussions that were held and how people's needs were to be met. We saw that health care professionals had previously worked closely with the home to assess people's needs in relation to communication and behaviours that may challenge. However, there was no recent evidence of such expertise being sought and utilised in people's care planning to ensure that their needs continued to be met.

People were encouraged to engage in activities in the community and records we sampled showed that staff had considered ways to help people explore and pursue interests. One person living at the home regularly attended a local day centre with which they were familiar. A relative told us, "[My relative] has come on leaps and bounds with all of the activities they do." Our discussions with another person's relative and staff confirmed that a person was supported to pursue their interests.

Further improvement was required to ensure people were supported to engage in activities of interest to them. Records we sampled and our discussions with staff showed that people had limited access to activities during the winter period. The registered manager confirmed this finding and told us that more consideration would be given to explore practical ways for people to maintain their interests throughout the year.

The registered provider had a formal complaints process and there was guidance on display at the home as to how visitors could share any feedback and concerns they may have. We saw however that such guidance was not made accessible for people living at the home. The registered manager told us a complaint that had been made recently was being investigated by the registered provider. A staff member was aware of how the service handled complaints and provided a recent example of a complaint that had been received. Relatives we spoke with described the registered manager as approachable. One relative told us, "I can talk to her and tell her if something is not right." Another relative told us that they would feel comfortable raising

complaints with the registered manager if they needed to do so.

All the people who lived at the home had done so for several years. One relative told us that they felt that their relative was happy living at the home. Another relative told us, "We are really happy that [the person] is there, and [the person] is happy, you can tell." Staff we spoke with showed that they were familiar with the people they supported. A staff member we spoke with who had worked at the home for a number of years provided examples of how people had progressed over time and commented, "People are happy here. I've seen the change in people… it shows this is really home [to people]." The registered manager told us that people had developed positive relationships with staff who knew them well.

The registered manager and staff had received compliments which referred to the positive experience of people, relatives and healthcare professionals. A compliment of November 2016 stated: 'The team at Maycroft should be proud of the support and care they have provided over the previous months. It has been a pleasure working with such a hardworking, caring and dedicated team.' A compliment in July 2016 referred to the ongoing supportive approach of staff over the time a person lived at the home and stated, 'Maycroft is a truly wonderful place where the residents are treated as individuals and are respected and loved for who they are.' The registered manager and staff had received praise for how they had supported one person throughout their time at the home, and how they had supported this person to leave the home after they had expressed a wish to do so. The home had received a written compliment stating that when supporting this person, staff had, 'Always given 100% time and effort… above what's expected.'

Requires Improvement

Is the service well-led?

Our findings

People were not always supported to become involved in their care and decisions about their daily routines. People were not always supported to maintain their independence, and we observed a 'task-orientated' approach where tasks were often 'done to' people rather than with them. The registered manager recognised our concerns and told us that action would be taken to address this. We informed the registered manager of concerns we had identified in relation to the culture of the home and approach of some staff. Records we sampled of the registered provider's audits showed that the concerns we identified were not isolated. Whilst the registered manager told us that they had taken appropriate action where such incidents had occurred previously, our findings showed that an inclusive, person-centred culture had not been sustained. The registered provider assured us that these concerns would be addressed.

Systems in place to assess, monitor and improve the quality and safety of the service were not effective. One staff member told us that they did not always feel supported in their role and that possible areas of improvement at the home were not explored by the registered manager. Relatives were provided with annual feedback questionnaires to seek their views and experience of the service, although measures for capturing the experience of people using the service were not effective. The registered provider routinely conducted quality visits to the home, some of which were based around the CQC key questions. The registered provider's quality checks included observations of people's care and discussions with staff and maintaining oversight of systems and processes in place to support the running of the home. Where audits had identified issues and areas of improvement, for example, in respect of record keeping, our inspection findings showed that some actions were not completed as planned to address and sustain such improvements. Whilst audits had identified some positive findings in respect of the culture and atmosphere of the home along with areas of improvement, quality assurance processes had not addressed clear and prevalent concerns and breaches of regulation in respect of the care and support of people living at the home.

The audit systems in place had failed to assess, monitor and drive improvements in the quality of the service people received. People were supported by staff who had supported them over a long period of time and who were familiar with their needs. Whilst this was positive and valued by the registered manager, we found that the approach to people's care was often guided by staff decisions that did not always consider the perspective and choices of the person. The registered manager told us, "We work with what we've got and what we know." People could not be confident that they would receive support in line with good practice guidelines. Records we sampled did not always provide correct and up-to-date guidance for staff as to people's needs.

The registered manager did not have sufficient oversight to ensure the quality and safety of the service and ensure that care and support was delivered in line with people's needs. Systems in place had failed to identify that records were not always robust and able to demonstrate that people were supported appropriately. The registered manager confirmed that they did not routinely monitor care records. One care record we sampled indicated that a staff member had prevented a person from accessing their preferred drink as they had refused to receive personal care. We brought this to the attention of the registered

manager who confirmed that the content of this care note reflected inappropriate support and told us that they would investigate this. Incidents and risks at the home were not monitored and explored over time to ensure that people were supported in line with current risks whilst promoting their independence.

Failure to effectively assess, monitor and improve the quality, safety and risks of the service; and to maintain securely accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not demonstrate clear understanding of their responsibilities in respect of the Duty of Candour and the Mental Capacity Act (2005). We identified that the registered manager had not displayed the most recent CQC inspection ratings at the home for up to fifteen months. Although we brought this to the attention of the registered manager, they took no action to rectify this during our inspection visit.

Failure to display the location's most recent rating of its performance by the Commission at the premises is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that they would be comfortable recommending the service to their own loved ones. One staff member commented, "It is a very loving and caring home." Most staff we spoke with told us that they had enough training for their roles and that they felt supported. One staff member told us that management were approachable and commented, "I know that if I have a problem, I can chat to them." Staff we spoke with did not consistently feel however that the registered manager was supportive and proactive in the running of the home.

The registered provider shared information with the registered manager about events and incidents that had occurred at their other services, to promote learning and reflection about the safety of the service. The registered provider also monitored performance at the home in respect of areas such as staff training, checking how processes were followed and sampling people's care records. The registered manager told us that they felt supported by the registered provider. The registered provider told us that they would continue with their development of 'active support' at the home which encouraged people's involvement in tasks, to help promote people's choices and independence. A staff member we spoke with told us about this and described how they considered this to be an example of progress at the home.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to provide people receiving care and treatment with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to provide care that balances the needs and safety of people using the service with their rights and preferences, and in accordance with the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to effectively assess, monitor and improve the quality, safety and risks of the service; and to maintain securely accurate, complete and contemporaneous records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider failed to display the location's most recent rating of its performance by the Commission at the premises.