Oban House Retirement Care Home

Oban House Residential Care Home

Inspection report

9-11, Victoria Drive
Bognor Regis
West Sussex
PO21 2RH

Tel: 01243863564
Website: www.obanhouse.org.uk

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection carried out on 10 January 2017.

Oban House Residential Care Home can provide accommodation and personal care for 30 older people. There were 14 people living in the service at the time of our inspection.

The service was run by a company who was the registered provider. There was 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. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that there were not always enough staff on duty to promptly give people the care they needed. We also found that quality checks had not been effective in resolving a number of problems in the running of the service. You can see what action we told the registered persons to take in relation to each of these breaches of the regulations at the end of the full version of this report.

In addition to these shortfalls we found that medicines were not consistently being managed in the right way and suitable steps had not always been taken to avoid preventable accidents. The procedure used to recruit new staff was not robust and parts of the accommodation were not clean and hygienic. Staff knew how to respond to any concerns that might arise so that people were kept safe from abuse, including financial mistreatment.

Some areas of the accommodation were not well maintained and people had not been reliably assisted to ensure they had enough nutrition. Although staff knew how to care for people in the right way they had not received all of the training and guidance that the registered persons said they needed. The registered persons had ensured that people's rights were respected by helping them to make decisions for themselves. The Care Quality Commission is required by law to monitor how registered persons apply the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005 and to report on what we find. These safeguards protect people when they are not able to make decisions for themselves and it is necessary to deprive them of their liberty in order to keep them safe. In relation to this, the registered persons had taken the necessary steps to ensure that people only received lawful care that respected their rights.

People's right to privacy was not fully promoted. Staff treated people with kindness and compassion. Confidential information was kept private.

People had been consulted about the care they wanted to receive and they had been given most of the assistance they needed. Positive outcomes were promoted for people who lived with dementia. People

were supported to express their individuality and they were helped to pursue their hobbies and interests. There was a system for quickly and fairly resolving complaints.

People had not fully benefited from staff acting upon national good practice guidance. People had been consulted about the development of their home and the service was run in an open and inclusive way. Good team work was promoted and staff were supported to speak out if they had any concerns.

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.

There were not enough staff on duty.

Medicines were not always managed safely.

People had not always been protected from the risk of avoidable accidents.

Background checks had not been fully completed before new staff were employed.

Parts of the accommodation were not clean and hygienic.

Staff knew how to keep people safe from the risk of abuse including financial mistreatment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had not always been fully assisted to eat enough.

Parts of the accommodation were not well decorated or maintained.

Staff had most of the knowledge and skills they needed to care for people in the right way and they had received most of the training and guidance they needed.

Care was provided in a way that ensured people's legal rights were protected.

People had been assisted to receive all the healthcare attention they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy was not fully promoted.

Staff were caring, kind and compassionate.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People had been consulted about the care they wanted to receive and most of this had been provided in the right way.

Staff promoted positive outcomes for people who lived with dementia.

People were supported to express their individuality and they were helped to pursue their hobbies and interests.

There was a system to quickly and fairly resolve complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality checks had not always led to problems being quickly resolved.

People had not fully benefited from staff acting upon good practice guidance.

People and their relatives had been asked for their opinions of the service so that their views could be taken into account.

There was good team work and staff had been encouraged to speak out if they had any concerns.

Oban House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons were 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.

Before the inspection, the registered persons completed a Provider Information Return (PIR). This is a form that asks them to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered person had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the local authority who contributed to the cost of some of the people who lived in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 10 January 2017. The inspection team consisted of one inspector and the inspection was unannounced.

During the inspection we spoke with seven people who lived in the service and with two relatives. We also spoke with four care workers, a housekeeper and the deputy manager. In addition, we met with the registered manager and with one of the directors of the company. We observed care that was provided in communal areas and looked at the care records for four people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

After our inspection visit we spoke by telephone with a further three relatives.

Requires Improvement

Is the service safe?

Our findings

Some of the people who lived in the service said that at busy times of day there were not always enough staff on duty to promptly meet their needs. One of them commented, "I'm looked after pretty well here but in the mornings the staff are rushed off their feet and you have to wait." Another person remarked, "The staff are too busy in the morning and in the evening too and this is particularly a problem if someone hasn't turned up for work and they're a person down."

We were told that the registered persons had carefully reviewed the care each person required and had calculated how many staff were needed. On the morning of our inspection visit we noted that one of the planned shifts for the care workers had not been filled. We were told that this was because a member of staff had become unwell and it had not been possible to arrange cover. We saw the two care workers who were on duty rushing to assist people to get up. We also noted that some people had to wait to be assisted out of bed and consequently were late having their breakfasts. Furthermore, between 9.15am and 10.00am we were heard the call bell sound five times. On four of these occasions staff were not able to respond within the timescale the registered manager said should have been achieved. We looked at records of the shifts that should have been completed by care workers over seven days in the month preceding our inspection. We found that on six of the days there had been periods of time when the service had not been staffed at the minimum level that the registered persons had said was necessary.

Shortfalls in the arrangements used to deploy staff had resulted in people not always promptly receiving care that met their needs and expectations.

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

We found that some medicines were not reliably being dispensed in the right way. We looked at the medicines that had recently been dispensed for three people. We found that in relation to two of them mistakes had been made for two of their medicines. This was because the record that staff should have made on each occasion the medicines were given had not been completed. In addition, it was not possible for the registered manager to use any other means to assure us that the medicines had actually been administered. Although other records showed that the people concerned had not experienced direct harm as a result of the mistakes, the problem had increased the risk that they had not benefited fully from using medicines in the manner intended by their doctors. We also noted that a medicine which had been prescribed for a person had been left by mistake in a communal bathroom. This had increased the risk that someone might have used the medicine when it was not safe for them to do so.

In addition, we noted that the service did not have robust arrangements to ensure that medicines were always stored at the right temperature. This was because regular checks were not being completed to make sure that they did not become too warm. This is important because when it occurs some medicines can lose part of their therapeutic effect. We raised our concerns about the management of medicines with the registered manager who said that steps would immediately be taken to address each of the problems we

had found.

We found that there were shortfalls in one of the arrangements that had been made to prevent people from experiencing avoidable accidents. We noted that windows located on the first floor had not been fitted with suitable restrictors to prevent them from opening too far. This increased the risk that people would be injured or would fall when opening the windows concerned. We also noted that the registered persons had not completed an up to date review of the steps that needed to be taken to help prevent people from having falls as they moved about their home and received care. Although records showed that most people had not experienced falls, the mistake had increased the risk that people would not be suitably assisted to avoid having accidents. In addition, we saw that some radiators were not fitted with guards resulting in the risk that people might touch their heated surfaces and burn themselves. A further shortfall was that the registered persons had not prepared written guidance for staff about how best to support each person in the event of an emergency. This may be necessary if there is a fire and people need to move to a safe area of the accommodation or need to evacuate the premises. The absence of these 'personal emergency evacuation plans' increased the risk that people would not reliably receive all of the assistance they needed.

However, staff had identified other possible risks that could lead to people having accidents. An example of this was some people agreeing to have rails fitted to the side of their bed so that they could be comfortable and not have to worry about rolling out of bed. Other examples were people being provided with equipment such as walking frames, raised toilet seats and bannister rails. In addition, staff had taken action to promote people's wellbeing. An example of this was people being helped to keep their skin healthy by using soft cushions and mattresses that reduced pressure on key areas.

We also noted that records of accidents and near misses in the service showed that most of them had been minor and had not resulted in the need for people to receive medical attention. We saw that the registered manager had analysed each event so that practical steps could then be taken to help prevent them from happening again. An example of this was people being offered the opportunity to be referred to a specialist clinic after they had experienced a number of falls. This had enabled staff to receive expert advice about how best to assist the people concerned so that it was less likely that they would experience falls in the future.

We looked at the way in which the registered persons had recruited two members of staff. Records showed that a number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the people concerned did not have relevant criminal convictions. However, we noted that in both cases the registered persons had not obtained a suitably detailed account of the applicants' employment histories. In addition and in relation to one of the applicants, the registered persons had not enquired into the reasons why they had left a number of previous jobs at which they had provided personal care. These mistakes had reduced the registered persons' ability to ensure that they had obtained all of the necessary assurances about the previous good conduct of the applicants in question. However, the registered manager told us that no concerns had been raised about any aspect of the performance of the two members of staff. In addition, the registered manager said that the registered persons would immediately complete all of the remaining checks for the staff concerned. They also said that the service's recruitment procedure would be strengthened to ensure that similar oversights did not happen again.

We found that parts of the accommodation were not clean and hygienic. In a number of places carpets in communal areas were stained and looked unsightly. In addition to this, the atmosphere in two of the four bedrooms we visited was not fresh. In each of these cases we noted that the carpet was soiled and could not be cleaned to achieve a suitable standard of hygiene. We also saw that a number of commodes placed in people's bedrooms were not fitted with lids. Although the commode pans were clean the absence of covers

was both unsightly and did not suitably protect people from the problem of cross infection. These various shortfalls had increased the risk that people would acquire avoidable infections.

People said that they felt safe living in the service. One of them said, "It's okay here. It's not posh but the staff are kind." Another person remarked who preferred not to speak gave a 'thumbs-up' sign when asked about this matter. All of the relatives with whom we spoke said they were confident that their family members were safe in the service. One of them said, "Yes, the service is fine and I'm happy that my family member is safe and well here."

Records showed that staff had completed training in how to keep people safe from situations in which they may experience abuse. We found that staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk of harm. Staff were confident that people were treated with kindness and said they would immediately report any concerns to a senior person in the service. In addition, they knew how to contact external agencies such as the Care Quality Commission and said they would do so if their concerns remained unresolved.

We found that people had been protected from the risk of financial mistreatment. This was because some people who needed help to manage their personal money were provided with the assistance they needed. Records showed that there was a clear account that described each occasion when staff had spent money on someone's behalf. This included paying for services such as seeing the hairdresser and chiropodist. In addition, we noted that there were receipts to support each purchase that had been made.

Requires Improvement

Is the service effective?

Our findings

People said that they were well supported in the service and they were confident that staff knew how to provide them with the practical assistance they needed. One of them said, "The staff know me inside out and they're very helpful." Relatives were also confident that staff had the knowledge and skills they needed. One of them said, "I'm confident in the staff because I can see that they know my family member well." Another relative said, "This place has got a family feeling to it. It's a bit rough and ready at the edges but the most important thing is that the staff have got it right and know what they're doing."

However, we noted that people had not always been given all the help they needed to make sure that they were eating enough to maintain their good health. We looked at the arrangements that had been made to support three people who were at risk of not eating enough to maintain their health and wellbeing. We noted that staff had correctly used a nationally recognised method to identify how frequently the people concerned needed to be offered the opportunity to check their body weight. However, there were significant shortfalls in how often this had been done. These mistakes had reduced the service's ability to quickly identify if someone's weight was changing in a way that needed to be brought to the attention of a healthcare professional. Although other care records showed that the people concerned had not experienced direct harm as a result of these oversights, the mistakes had increased the risk of people not being supported to receive sufficient nutrition. We raised our concerns with the registered manager who said that immediate steps would be taken to address each of the problems we had noted.

However, records showed that staff had arranged for some people who were at risk of choking to be seen by a healthcare professional. As a result of this, staff had been advised how to specially blend some people's meals so that they were easier to swallow.

People told us that they enjoyed their meals with one of them remarking, "The meals are pretty good here. Certainly, I always get enough to eat and it's tasty." Another person remarked, "I quite look forward to meal times and the food is okay. I've no complaints that score." Records showed that people were offered a choice of dish at each meal time and when we were present at lunch we noted that the meal time was a relaxed and pleasant occasion. People chatted with each other and with staff as they dined. In addition, we saw that some people were given individual assistance to make it easier for them to dine in comfort.

We found that parts of the accommodation were not well decorated and maintained. In numerous places we noted paintwork to be chipped and discoloured. Some of the veneered bedroom doors were pock marked with numerous chips and scuffs. The door leading to the communal walk-in shower had a hole in its surface and inside the room there were various broken fixtures and fittings. The appearance of this room was further compromised by a water pipe that had been crudely fitted to the wall and left unpainted after the shower had been installed several months earlier. In addition, in a number of places windows could not be closed to achieve a weather-tight seal. This was because the handles were broken. All of these defects in the accommodation detracted from the registered persons' ability to provide people with a welcoming setting in which to make their home. Speaking about this a person remarked, "It is a bit run down. The owner's do their best but it's one thing after the other for them I suppose to put right."

Staff told us that the registered manager spent a lot of time in the service and regularly worked alongside them to provide care for people. This was done so that they could give feedback to staff about how well the assistance they provided was meeting people's needs and wishes. We also noted that all of the care workers had either obtained or were working towards a nationally recognised qualification in the provision of care in residential settings.

Staff told us and records confirmed that new staff had undertaken introductory training before working without direct supervision. The registered manager said that this training complied with the guidance set out in the Care Certificate. This is a nationally recognised model of training for new staff that is designed to equip them to care for people in the right way. However, there were no records for us to see to confirm that the model was being used in the right way to give staff the high quality initial training they needed.

Documents showed that the registered persons considered that staff needed to regularly receive refresher training in key subjects. They said that this was necessary so that staff knew how to safely care for people in the right way. The subjects included how to safely assist people who experienced reduced mobility, first aid, infection control and fire safety. However, we noted that most staff had not completed all of the required training. Nevertheless, records showed that there were plans in place to address this oversight in the near future. Also, we found that staff had the knowledge and skills they needed to consistently provide people with most of the care they needed. An example of this was staff knowing how to correctly assist people who needed support in order to promote their continence. Another example was staff having the knowledge and skills they needed to help people keep their skin healthy. Staff were aware of how to identify if someone was developing sore skin and understood the importance of quickly seeking advice from an external healthcare professional if they were concerned about how well someone's treatment was progressing.

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 law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that the registered manager and staff were supporting people to make various decisions for themselves. An example of this occurred when we saw a member of staff explaining to a person who lived with dementia why it was advisable for them to use a medicine at the correct time in order to stay well. The member of staff pointed to the medicine in question and then to a nearby clock to indicate that it was the usual time for them to accept medicines. We noted how the person responded positively to this information after which they were pleased to receive the medicine in question.

Records showed that the registered manager recognised the need to work with key people when a person lacked mental capacity and a decision needed to be made about their care. We saw that they had liaised with health and social care professionals and relatives to make sure that important decisions were taken in a person's best interests. An example of this was the registered manager working with care managers (social workers) and relatives after a person who lived with dementia had developed additional needs for support. They had done this so that careful consideration could be given to deciding whether the person would benefit from moving to a more specialised service.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the registered manager knew about the requirements of the Deprivation of Liberty Safeguards and recognised

the importance of ensuring that people were only provided with care that protected their legal rights.

Records showed that some people had made legal arrangements for a relative or other representative to make decisions on their behalf if they were no longer able to do so for themselves. We noted that these arrangements were clearly documented and were correctly understood by the registered manager. This helped to ensure that suitable steps could be taken to liaise with relatives and representatives who had the legal right to be consulted about the care and assistance provided for the people concerned.

People said and records confirmed that they received all of the help they needed to see their doctor and other healthcare professionals. A person spoke about this and said, "The staff are very quick to call the doctor if I'm unwell. They don't hang around." Relatives also commented on this matter with one of them saying, "I know that the staff do call the doctor straight away and they also tell me if they're got any concerns about my family member's health."

Requires Improvement

Is the service caring?

Our findings

People were positive about the quality of care that they received. One of them said, "I think that the staff are great and they're genuinely kind people." Relatives also told us that they were confident that their family members were treated in a compassionate way. One of them said, "I get on well with the staff. They're always very welcoming and there's a relaxed and informal atmosphere here." Another relative remarked, "I've not had to worry about my family member being safe ever since they moved into Oban House."

However, we found that suitable provision had not been made to enable staff to fully promote people's privacy. This was because none of the bedroom doors were fitted with working locks and so people could not secure their personal space if they wanted to do so. We also noted that the sliding doors to the communal bathroom and walk-in shower were too stiff for any of the people who lived in the service to use. In addition, one of the doors did not have a working lock and the lock on the other door was misaligned and very awkward to operate. However, we saw that staff recognised the importance of not intruding into people's private space. People had their own bedrooms and private bathrooms. The bedrooms were laid out as bed sitting areas. This meant that they could relax and enjoy their own company if they did not want to use the communal lounges. We also saw that staff had supported people to personalise their rooms with their own pictures, photographs and items of furniture. We saw staff knocking before going into bedrooms and making sure that doors were shut when they assisted people with close personal care.

During our inspection we saw that people were treated with respect and with kindness. Although staff were busy they made a point of speaking with people as they assisted them. We observed a lot of positive conversations that supported people's wellbeing. An example of this occurred when we heard a member of staff chatting with a person about their joint experiences of living and working in the area. The person concerned was pleased to reflect upon how over the years shops had opened and closed in Bognor Regis.

We saw that staff were compassionate and supported people to retain parts of their lives that were important to them before they moved in. An example of this involved a member of staff speaking with a person about one of their relatives who they did not see regularly because they did not live in the area. The member of staff encouraged the person to enjoy recalling when they were younger and regularly saw their relative more frequently.

We noted that there were arrangements in place to support someone if they could not easily express their wishes and did not have family or friends to assist them to make decisions about their care. These measures included the service having links to local lay advocacy groups. Lay advocates are independent of the service and who could support people to express their opinions and wishes.

We noted that people could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wished to do so. A relative commented on this saying, "I normally stay in the lounge but I could use my family member's bedroom if there was something private I wanted to talk about. I'm sure that the staff would be fine with that." In addition, we noted that people could use the service's business telephone from the comfort of their bedroom if they wanted to make or receive a call in private.

We saw that paper records which contained private information were stored securely. In addition, electronic records were held securely in the service's computer system. This system was password protected and so could only be accessed by authorised staff. We found that staff understood the importance of respecting confidential information and only disclosed it to people such as health and social care professionals on a need-to-know basis.

Good

Is the service responsive?

Our findings

People said that staff had consulted with them about the care they wanted to receive. We noted that the results of this process were recorded in an individual care plan for each person. People said that staff provided them with a wide range of assistance including washing, dressing and using the bathroom. Records confirmed that each person was receiving the practical assistance they needed as described in their care plan. An example of this was people being helped to reposition themselves when in bed or when seated in their armchair so that they were comfortable. Another example was the way in which staff had supported people to use aides that promoted their continence. In addition, people said and records confirmed that staff regularly checked on them during the night to make sure they were comfortable and safe in bed. Speaking about the care they received a person said, "The building is a bit run down but the care is good. You might have to wait a bit for the staff to come but they do give me all the help I need once they've got around to me." Another person remarked, "if I need help at night all I need to do is ring the bell. They're less busy at night and so they can pretty much come straight away. They're nice about it too, so I don't feel I'm being a nuisance."

We noted that staff promoted positive outcomes for people who lived with dementia. We saw that when a person became distressed, staff followed the guidance described in the person's care plan and reassured them. They noticed that a person was becoming upset because they were not sure when they would be assisted to go to the dining room for their lunch. The member of staff quietly explained to the person when their lunch would be served and then asked them if they would like a snack in the meantime. Shortly after this we saw the person choose to enjoy a sweet while they sat in a quiet area of the lounge watching a television programme. The member of staff had known how to provide the person with the reassurance they needed.

People told us that they were satisfied with the opportunities they were given to enjoy social activities. One of them said, "The staff lay something on for us on most days. I like joining in and we have a bit of a laugh together." Records showed that people had been supported to take part in a range of social activities including things such as arts and crafts, quizzes and gentle exercises. In addition, we noted that entertainers called to the service to play music and engage people in singing along to their favourite tunes. During the course of our inspection we saw a number of people taking part in a quiz after which everyone was given a small prize. Later on in the day we saw several people enjoying having their nails polished. One of them said, "It's good this, I like the individual attention and having my nails looking so smart."

We noted that people's individuality was respected and promoted. We were told that arrangements had been made for several people to regularly meet their spiritual needs by seeing a vicar or a priest. In addition, the registered manager was aware of how to support people who had English as their second language. This included being able to make use of translator services. We also found that suitable arrangements had been made to respect each person's wishes when they came to the end of their life. This included establishing how relatives wanted to be supported to acknowledge and celebrate their family member's life.

People and their relatives said that they would be confident speaking to the registered manager if they had

any complaints about the service. A relative said, "I've not had to complain about anything really. If there was something the manager really is a lovely person and I know that she'd do whatever she could to put something right."

We saw that each person who lived in the service had received a document that explained how they could make a complaint. In addition, the registered persons had a procedure that was intended to ensure that complaints could be resolved quickly and fairly. Records showed that the registered persons had received one formal complaint in the 12 months preceding our inspection. We noted that the investigation of the complaint was being overseen by the local authority. This was because concerns had been raised that a person who lived in the service may have not received all of the care they needed to protect them from the risk of neglect. Records showed that the registered manager had suitably investigated the matter and had quickly informed the local authority that the person had received all of the care they needed.

Requires Improvement

Is the service well-led?

Our findings

People told us that they considered the service to be well managed. One of them said, "Things are okay here for me. The place runs well enough with no major upsets that I can see." Relatives were also complimentary about this with one of them commenting, "I do think that the service is quite well run. The manager is very approachable and the staff are fine but they're too busy some of the time."

In their Provider Information Return the registered persons said that they used robust systems to check on the quality of the service people received. However, we found that although various quality checks had been completed often they had not been effective in quickly putting problems right. In more detail, we found that each of the problems we identified in the running of the service had been the subject of quality checks which had not clearly identified the need for improvements to be made. These included the mistakes we have described earlier in our report relating to deploying staff, managing medicines, preventing avoidable accidents and recruiting staff. Other problems that had been checked but not addressed included supporting people to have enough nutrition, promoting suitable standards of hygiene and providing a well maintained setting. In addition to these problems, we noted that some of the checks of the fire safety system had not been completed in the right way. This had reduced the level of protection people could be given in the event of a fire.

We also noted that the registered persons had not provided all of the leadership necessary to enable people who lived in the service to benefit from staff acting upon good practice guidance. Examples of this were the service not having subscribed to important nationally recognised schemes that are designed to promote high standards in social care settings. This oversight had contributed to the continuation of the problems we have noted above.

Shortfalls in assessing and monitoring the quality of the service had reduced the registered persons' ability to protect and promote the health, safety and welfare of people who lived in the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said that they were asked for their views about their home as part of everyday life. One of them remarked, "We have a chat with the staff and the manager and the owners are around quite a lot. If I wanted something or had a bright idea I think that they'd be interested and would try to do what I suggested." In addition, we noted that people had been invited to suggest improvements to their home by contributing to regular house meetings and by completing an annual quality assurance questionnaire. We saw that when people had suggested improvements action had been taken to introduce them. Examples of this were changes that had been made to the menu and the provision of new and different social activities.

People and their relatives said that they knew who the registered manager and the directors of the company were and that they were helpful. During our inspection visit we saw the registered manager and one of the directors talking with people who lived in the service and with staff.

We noted that there were measures in place that were intended to develop good team working. There was a senior member of staff in charge of each shift and during out of office hours the registered manager was on call if staff needed advice. Staff said and our observations confirmed that there were handover meetings at the beginning and end of each shift when developments in each person's care were noted and reviewed. In addition, there were staff meetings at which staff could discuss their roles and suggest improvements to further develop effective team working.

There was an open and relaxed approach to running the service. Staff said that they were well supported by the registered manager. They were confident that they could speak to them if they had any concerns about another staff member. Staff told us that positive leadership in the service reassured them that they would be listened to and that action would be taken if they raised any concerns about poor practice.

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 17 HSCA RA Regulations 2014 Good governance The registered persons had not established robust arrangements to assess and monitor the quality of the service. This shortfall had reduced their ability to protect and promote the health, safety and welfare of people who lived in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had not suitably deployed staff to ensure that people promptly received care that met their needs and expectations.