Supreme Care Services Limited

Fir Trees House

Inspection report

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Surrey
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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?	**Inadequate**

Summary of findings

Overall summary

Fir Trees House is a care home providing accommodation and personal care for up to seven people with learning disabilities or mental health support needs. There were seven people living at the service at the time of our inspection.

The inspection took place on 12 November 2016 and was unannounced.

There was no 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. A manager had been in post for three months and supported us during our inspection. Records showed that the manager had begun the process of registration with the CQC.

At our last inspection in October 2015 we found breaches of the legal requirements in relation to risks to people's safety not being adequately addressed, the requirements of the Mental Capacity Act 2005 not being followed and the lack of management oversight of the service.. The provider wrote to us to inform us of the action they planned to take to address the concerns. This comprehensive inspection was conducted to check that the action had been taken by the provider and that they were now meeting their legal requirements. We found that the provider had made improvements in some areas which had led to positive changes for people. However, the provider had failed to address a number of issues in relation to people's safety and well-being, protecting people's rights and the management oversight of the service.

There was a lack of management oversight of the service. Quality audits were not effective in identifying shortfalls in the service and feedback received was not always acted upon. The manager had been in post for three months. Due to vacancies within the senior management team they were not receiving effective support during their probationary period.

Risk assessments were not completed comprehensively and did not identify control measures to minimise the risks to people safety and well-being. A number of people living at Fir Tree Road displayed behaviours that challenged and records showed there were times people had felt unsafe. Where safeguarding concerns had been recorded these had not been forwarded to the local authority safeguarding team. Incident records were not analysed to identify what actions were required to minimise the risk of reoccurrence.

Staff did not receive effective training to support them in their role and had not put their training into practice in regards to safeguarding and compliance with the Mental Capacity Act 2005. Since the last inspection staffing levels had reduced which meant people were not always offered support flexibly. We have made a recommendation regarding this.

People's legal rights were not always protected as the staff were not working in line with The MCA and DoLS

legislation. Whilst some people's care plans contained information regarding the likes and dislikes other people's plans lacked detail and guidance for staff.

A number of activities were provided for people although staff told us they felt more could be achieved. We have made a recommendation regarding developing the opportunities available to people. A number of people living at the service were able to plan their own activities and daily routines.

Medicines were managed safely and staff understood the process involved in supporting people with their medicines. Maintenance of the premises and equipment were monitored and health and safety checks of the environment were completed. There was a contingency plan in place to ensure that people would continue to receive a service in the event the building could not be used.

Safe recruitment practices had been followed to ensure that the staff employed were of a suitable character to provide people with care and support. Staff told us they felt supported by the manager and records showed that regular supervision of staff was undertaken.

People's healthcare needs were monitored by staff and they were supported to access relevant health professionals in a timely manner when they needed to. People told us that they enjoyed the food provided and we observed people were involved in the planning and preparation of meals.

People were supported by staff who treated them with kindness. People told us they felt comfortable speaking to staff and we observed positive and caring interactions during the inspection. People were supported to develop their independent living skills and were actively involved in domestic tasks. People were supported to maintain relationships with family and other people who were important to them.

People and staff were involved in the running of the service. Regular meetings were held to gain feedback and people told us they felt listened to. There was a complaints procedure in place and clearly displayed. People told us they would feel comfortable in raising 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 always safe.

People were not protected from the risk of harm as control measures and guidance for staff in managing risks were not in place.

Safeguarding incidents had not been reported to the local authority.

Accidents and incidents were not monitored to reduce the risk of incidents being repeated.

Staff were not always deployed effectively to ensure people's needs could be met flexibly.

Safe recruitment practices were in place

People received their medicines safely and in line with prescribed guidelines.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not protected as the principles of the MCA were not followed.

People were supported by staff who had not received appropriate training to ensure they were competent to carry out their roles.

People were provided with food and drink which supported them to maintain a healthy diet.

People were supported to maintain good health and had regular access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People's needs were not always put at the centre of the service.

Staff supported people in a caring way and respected their privacy.

People were involved in the daily routines and independence was encouraged.

People were supported to maintain contact with family members and others who were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The quality of care plans varied. Not all plans contained details of people's lifestyle and preferences.

Activities plans for people were not always consistent although people did have access to a range of activities.

There was a complaints policy and procedure in place which was displayed in an easy read format.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance audits were not effective in ensuring continuous improvement.

Feedback regarding the service was not always acted upon.

The manager was not receiving effective support from the provider.

People and staff said the manager was approachable and responsive.

Fir Trees House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 November 2016 and was unannounced. The inspection was carried out by two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We spoke to six people living at Fir Tree Road about their experience and observed the care and support provided to them. We spoke to the manager and two staff members during the inspection.

We reviewed a range of documents about people's care and how the home was managed. We looked at four care plans, medication administration records, risk assessments, accident and incident records, complaints records, policies and procedures and staff records.

We last inspected the service in October 2015 when we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2015 we found that risks to people's safety were not consistently assessed and guidance was not always provided for staff to enable them to minimise risks. At this inspection we found that these concerns had not been adequately addressed.

During the inspection people told us they felt safe living at Fir Tree Road. One person said, "I feel safe because I like the staff and they're here to help us." Another person told us, "I never have any incidents with the staff." During the inspection we found the atmosphere was friendly and relaxed although records showed that people had experienced incidents which had led to them feeling anxious and unsafe.

Risk assessments were not always in place to keep people safe and there was a lack of consistency in the way staff supported people. Where assessments had been developed these lacked detail and guidance for staff to follow in order to reduce or prevent risks from occurring. A number of people living at the service displayed behaviours which put themselves and others at risk of harm. People's files did not contain guidance regarding triggers to people's behaviours or how staff should intervene to support people in these situations. Records showed that there was a lack of consistency in the way staff responded to people during incidents. Incident forms detailed that there had been occasions where people had been assaulted by others living at the service and the police had been involved. Risk assessments had not been updated following these incidents.

Records for one person showed that they had been frightened and anxious after an incident and had remained in their room with their door locked to feel safe. Resident meeting minutes also showed that people had asked that staff address one person's behaviour as it was causing them to be 'fed up'. Although guidance from the person's previous home was available this had not been updated or reviewed and risk assessments were not in place. Although staff were aware of the triggers to the person's behaviours they were unable to describe how they supported and reassured the person to minimise the risk of incidents occurring. Another person's behaviour monitoring chart showed that on four occasions in October they had been verbally aggressive towards others. There was no guidance available to staff as to how they should support the person with these issues. Staff told us they found the situation difficult as the person was able to access the community independently and incidents occurred on their return. This meant staff were unable to monitor the person or manage the situation when they returned and became abusive. One staff member told us, "We just have to deal with it. It will need to be reviewed if it carry's on. It's not fair on people." Risks to the person's safety when they were out without support had not been assessed although their care file identified they were at high risk of falls.

One person had displayed behaviour when in the community without support which had led to on-going police involvement. Staff were aware of the incidents and were able to describe the restrictions which had been placed upon the person. However, risks to the person and others had not been adequately assessed to protect them when they accessed the community without staff support. The person's assessment and care plan highlighted they posed a 'significant risk to other people and self-harms'. Risk assessments in place stated, 'staff to identify potentially volatile discussions and arguments and try to de-escalate'. There was no

guidance for staff on how to support the person with their behaviour or identify triggers.

During our last inspection we highlighted one person's activities in the community were limited due to their behaviour and anxiety. Staff had told us that the person was reluctant to access the community and they were unsure of the best way to support them. At this inspection we found that a risk assessment had been implemented which guided staff to support the person to use taxi's rather than public transport to reduce the person's anxiety and minimise risks. However, there was no further guidance to staff on how to support the person's behaviours and we found that their access to the community remained limited.

Accidents and incidents were not monitored effectively to minimise the risk of reoccurrence and keep people safe. Records showed that staff recorded incidents in detail and made senior staff aware. However, there was no system in place to review how incidents were dealt with and what further action was required to try to prevent them reoccurring. Records did not show what action had been taken following incidents to ensure a co-ordinated approach was taken which addressed the issues raised.

The failure to adequately assess risks and take action to mitigate known risks to protect people from harm is a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of harm as procedures were not in place to ensure that the local authority were notified of safeguarding concerns. The incidents described above where people had been assaulted by others had been reported to professionals involved in their care. However, we were unable to find evidence that this and other incidents had been investigated and reported to the local safeguarding authority to enable them to gain an overall view of the service and take any appropriate action in relation to these concerns. Following the inspection the manager confirmed they had contacted the local authority safeguarding team to give an overview of the incidents which had taken place.

The failure to have and use an effective system for protecting people form abuse or harm is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always sufficiently deployed to ensure people's needs could be met flexibly. Staff told us and records confirmed that staffing levels had reduced since our last inspection. Two staff members were available to support people during the day with the assistance of the manager when present. Staff told us these numbers were sufficient when no one required support to access the community but that they did not feel it was safe to leave one staff member one their own. One staff member told us, "It causes a big burden on staff when we're on our own. (Name) gets angry if staff are busy and can't respond immediately." Another staff member told us, "It's okay when the manager is here to help but staff shouldn't be lone working. (Name) can blow up at any time. If we need to go out then I call the manager to come, they try to help a lot." Rota's confirmed that two staff members were scheduled to work during the day with a waking night and sleep-in staff member at night.

We recommend that rota's are planned to meet people's needs and so that staff can respond promptly and safely to these needs.

People received their medicines in line with their prescriptions and systems were in place to ensure medicines were stored, administered and recorded safely. One person told us, "Staff give me my medicines, morning, noon and night. I get it on time and they do it right." Staff received training in the administration of medicines and their competency in supporting people was assessed. People's Medication Administration Records (MAR) charts contained an up to date photograph and any allergies were clearly listed to avoid

errors occurring. There was an up to date staff signature list to identify which staff had signed to confirm medicines had been administered. MAR charts were fully completed and where people had refused there medicines this was recorded. There were clear protocols in place for the administration of PRN (as required) medicines to ensure these were administered appropriately.

Recruitment checks were completed which ensured people were supported by staff who were suitable to work in the service. Staff records included application forms, references from previous employers, proof of the person's identity and Disclosure and Barring Service (DBS) checks. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Records showed and staff confirmed they had undergone a face to face interview prior to being employed to check their suitability and skills.

Records confirmed that checks of the building and equipment were carried out to ensure people's health and safety. Relevant checks had been carried out on the fire equipment, gas appliances and electrical installation. Staff completed regular visual checks of the environment and maintenance issues were reported and rectified promptly. Personal emergency evacuation plans were in place to alert staff and the emergency services of the support people would require to exit the building safely. A service contingency plan had been completed which detailed where people would be evacuated to in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

Although staff had received training relevant to their role this had not always been effective in ensuring people received safe and effective care. The manager maintained a training matrix which recorded the training staff had undertaken. The matrix showed that all staff had completed safeguarding training. Staff we spoke to were able to describe the different categories of abuse and reporting procedures. However, they were unable to demonstrate their learning in practice as safeguarding concerns had not been reported to the local safeguarding authority by managers. Despite staff recently completing MCA training they were unable to tell us the requirements of this legislation and were unable to describe their responsibilities in ensuring people's right were protected. The provider had identified that due to the needs of the people living at Fir Tree Road staff required training in supporting people who may display behaviour which could be challenging. Records showed that two staff members had attended this training and the manager informed us that the remaining staff team were scheduled to attend the training in January 2017.

Failing to ensure that staff receive effective training to carry out their role was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff received an induction when starting work at the service which gave them the opportunity to learn about people's needs and the day to day running of the service. Staff told us they had the opportunity to shadow more experienced staff members prior to working unsupervised. One staff member said, "I came from a similar setting in my last job but I still had an induction. I shadowed another member of staff for a week so I could get to know about the residents, the house and their medication. It was useful to me."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in October 2015 we found that mental capacity assessments had not been completed for specific decisions. During this inspection we found that previous restrictions on a person with specific needs were no longer in place. Staff told us that they felt it would be unsafe for one person to leave the service without staff support as they would not recognise danger. As the person was reluctant to access the community staff did not feel this had an impact on the person. The persons care plan stated they were able to make their own decisions although it later stated they required some help with making financial decisions. There was no mental capacity assessment in place regarding the persons need for constant supervision or financial support and no DoLS application had been submitted to the local authority. Other people living at the service had full assumed capacity and were not subject to any restrictions. All communal areas were accessible and external doors were unlocked.

We recommend that the provider implements systems to ensure the principles of the MCA and DoLS legislation are followed.

People were involved in planning meals and choices were offered. There was a menu plan in place and people told us that this was discussed during meetings. One person told us, "We go by what's been put on the menu but we can have something else if we want." The manager had recently implemented a rota for people being supported to prepare meals. People told us that they were enjoying this and reacted positively when this was discussed. One person told us, "It's my day on a Sunday. Staff help us and I like doing it." We observed another person making lunch. Although they told us they were nervous in case it went wrong, they were smiling and enthusiastic. Everyone was very complementary about the meal they prepared which smelt and looked appetising. The person told us, "I'm loving it." They were clearly pleased with the outcome of the meal and the positive feedback. People were prompted to make drinks throughout the day. People's weight was monitored regularly and records showed that no one had experienced any significant fluctuations. Staff told us that if the monitoring showed any significant changes they would notify the GP.

People had access to relevant health and social care professionals when required. People told us that they were supported to attend health appointments and staff took action when they were unwell. One person told us, "The take good care of us. If I'm not well they take me straight to the doctors. When I was ill they took me hospital and staff came to visit me." Each person had a health action plan in place which detailed the support people required with their healthcare and the outcomes of appointments attended were recorded. Hospital passports were completed to provide important information about the person's needs should they be admitted into hospital.

Requires Improvement

Is the service caring?

Our findings

People appeared to enjoy the company of staff and were calm and comfortable in their presence. One person told us, "The staff are all great, they all listen. You can have good conversations with staff. If I need to talk I can always go to them." Another person told us, "They all do very well, nice and caring. I like all the staff and they always say I can tell them if I have a problem and they'll help me sort it out."

Despite these comments we found that people were not always put at the centre of the service. Although we observed people and staff had frequent friendly conversations this was largely initiated by people and responded to by staff. The lack of opportunities to engage in activities did not support people to develop confidence and a meaningful role within their local community. The incidents previously reported where people had been assaulted had not been adequately responded to which demonstrated a lack of understanding as to the impact this had on people's well-being.

We recommend the provider ensures that people's needs are placed at the centre of the service.

At our last inspection in October 2015 we found that staff completed domestic tasks and did not involve people in developing their skills in these areas. At this inspection we found that improvements had been made and people were now more involved in the day to day running of the home. People were encouraged to answer the door and on arrival one person greeted us and asked if we would like a drink which staff supported them to make. This showed that staff acknowledged Fir Tree House as people's home.

People were actively encouraged to take part in daily living tasks. The manager told us that since being in post they had begun to implement systems to ensure people developed their independence and skills. Staff confirmed that people were now more involved and that the manager was keen to develop this further. One staff member told us, "People are being involved now every day, the manager has made it clear this should happen and we talk about it in staff meetings." We observed people were supported to do their own laundry, clean their rooms and cook meals. People were clearly engaged in completing the task and told us they enjoyed being involved. One person told us, "I love doing it, staff always have good ideas and help us."

Staff treated people with kindness and understanding. One person told us, "I don't have to tell you how nice staff are, you can see it. They always treat me well." We observed a staff member ask one person if they were okay. The person told them they were worried that no-one liked them and the staff member reassured them by saying, "Everyone loves you." The person took the staff members hand and they chatted and laughed together. The manager was due to take annual leave the following week. We observed one person give them a hug and telling them they were going to miss them whilst they were away. The manager reciprocated and reassured them they would be back soon. Another person began to get anxious about who would support them to book a taxi the following week when they were due to meet their family. Staff supported the person to look at who was working that day and left a message in the communication book to ensure this was done. The person was reassured by this and told other staff what would be happening.

People's privacy and dignity was respected. Staff knocked on people's doors before entering, they ensured

that bedroom and bathroom doors were closed during care and prompted people to attend to their own care needs as required. One person told us they preferred to spend their time alone in their room and this was respected by staff. They told us, "They are very nice people, they don't interfere with me." We asked staff how they resected people's privacy when supporting them with personal care. One staff member told us, "I ensure that doors are closed, that it is warm for them and they are covered as much as they can be."

People were supported to keep in contact with relatives and friends. Staff members supported one person to travel to their family home on a weekly basis which they told us was important to them. Staff supported another person to arrange visits from a friend and on occasion to go for coffee together. One person told us their family regularly visited them, "They're always made welcome here and they get on with all the staff." At the time of the inspection one person was in hospital. The manager arranged for three people to visit the person the following day.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that care plans were difficult to read and did not cover all aspects of people's needs. At this inspection we found that improvements had been made although further development was required.

The content of the information contained within care plans varied. Some people's plans contained limited information regarding their likes and dislikes and how they preferred to be supported. One person had a specific need that required support and for staff to be aware of their condition. There were no details about this in the care plan to guide staff. Another person's daily records showed that they regularly called the emergency services inappropriately although there was no support plan in place to guide staff on how to respond and support the person in this area.

Other people's plans were person centred and contained detailed information regarding people's life history and preferences. One person's file contained information regarding the way they were supported to budget their finances. The person confirmed that staff supported them in this area. They told us, "Staff help with my budget plan. If I don't have one I spend all my money so staff help me so I can do nice things like go to shows and shopping." Another person's plan stated they preferred to have their breakfast before a shower and medicines afterwards. Staff knew the person and their plan of care well enough to follow and respond to their preferences and as a result the person interacted well with the staff .

People were involved in regular reviews of the care plans and health care professionals were also invited as appropriate. One person told us they had discussed finding a job and the things they were interested in during their last review. Records showed that staff had acted on this persons aim and were talking to relevant agencies to try to help the person secure a job. One professional had commented that staff, 'Followed direction regarding support needs. Any concerns were heard and taken as advice not criticism." Keyworker meetings took place monthly and gave an overview of what people had achieved in the past month. However, we noted that goals for the following month were not always planned and support needs were not always discussed to ensure any changes were reflected. .

We recommend that the provider ensures people's care plans reflect people's personalised care needs and provide staff with information on how to respond to those needs.

People spent long periods of the day with no planned activities and staff did not respond to opportunities to engage in activities with people. Two people spent the majority of their day watching television and one person spent time alone in their room. Staff did not sit with people and discuss what they were watching or chat with them. Three people went into the garden and had a short game of football. Staff did not take the opportunity to join the group and extend the activity. On another occasion one person went outside to work on their bike for a short time. Staff did not offer to help the person or talk to them about what they were doing. When staff took time to bake a cake with someone in the afternoon we observed the person became focussed and relaxed. They enjoyed sharing the cake with others and the positive feedback they received.

People's care records contained activity plans although these were not always accurate and up to date. One person's activity plan stated they attended a church group every two weeks and the local church service on a Sunday. We spoke to the manager regarding the person's plan as daily recording did not show these activities were taking place regularly. The manager told us that visits to the church group had been reduced due to the cost incurred of using taxis. They had tried to encourage the person to attend the local church but they had not enjoyed this. The staff were currently looking at ways of reducing the cost of travel to the person's preferred group. In addition the person's activity plan stated they went to the cinema weekly and for local walks and coffee with staff. However, staff told us that as the person refused to go out they did not take part in these activities. Although all staff referred to the person's reluctance to go out regularly their records showed they had recently been on holiday with their church group and occasionally accepted support to go for a coffee with a friend. Staff were unable to tell us what strategies were in place to develop the person's confidence and increase their opportunities.

Staff told us they felt that people needed more activities and the manager had identified this was an area which required development. One staff member told us, "We do things in and out of the house but with more staff we could do more." Another staff member told us, "We need more activities for people. We have been discussing how to persuade people to do more." The manager confirmed that they had identified people would benefit from increased activities both when at home and within the community.

We recommend that opportunities for people to participate in activities of their choice are further developed.

A number of people planned activities independently throughout the week. One person told us they visited the local shops and had a drink in the café every day. Another person arranged visits to meet their family members in the local town once a week. One person told us they attended a day service several days a week and a church group with friends one evening each week. They told us that they occasionally visited the theatre to see shows and records confirmed this was the case.

There was a complaints policy and procedure in place which was also displayed in an easy read format to enable people to understand how to raise a concern. People told us that if they wished to raise a complaint they would feel comfortable in discussing this with staff or the manager. One person told us, "Any problem's I would tell the manager and they would sort it out." Feedback gained from relatives stated, "I feel my concerns would be listened to." The complaints log showed one complaint had been made since the last inspection with regard to staff talking in the kitchen. The manager had spoken to the person concerned and apologised for the disruption caused.

Inadequate

Is the service well-led?

Our findings

People told us they felt the new manager was approachable and we observed the manager interacting positively with people. One person told us, "(Manager) is doing really well. We talk honestly and if there's a problem (manager) will tell you to your face." Staff told us they felt the service had improved since the manager was in post. One staff member told us, "(Manager) has made a positive difference to the house and engages with everyone." Despite these positive comments and the progress made to improve the service by the new manager the provider had failed to meet the regulations following the last inspection or to adequately support the new manager.

At our last inspection in April 2016 we identified concerns regarding the lack of quality auditing systems, meetings with people and staff were not recorded and feedback received was not acted upon. During this inspection we found that although some improvements had been made there was still a lack of management oversight of the service.

There was insufficient monitoring of the quality of the service. The manager and staff had completed a range of audits, however; these were not effective in identifying or addressing all of the shortfalls in the quality of the service we identified. Although care plan audits were completed monthly they were a tick box style which did not allow for any comments regarding the quality of the plans and did not monitor if information was up to date. Risk assessment audits followed a similar style and had not identified shortfalls in the information available to staff. The manager told us that the regional manager had completed a quality audit prior to leaving the organisation. However, the manager did not have access to this and was unable to obtain a copy when requested. We asked the manager if there was an action plan in place which identified continued plans to develop the quality of the service. The manager told us they were not aware of any current action plan. They said they had spent time getting to know the service and had implemented some immediate changes such as involving people in daily living tasks and reviewing activities. They planned to develop an action plan in the near future. Our discussions with the manager confirmed that they had a good understanding of people's needs.

There was no registered manager in post and the current manager was not receiving consistent support to settle into their role. Although the previous manager had only recently completed their de-registration from the service, they had left the employment of the provider in May 2016. The service had been overseen by a regional manager during the recruitment process. The manager had been in post for 3 months and told us they had begun the process of registering with the CQC. Our records confirmed this was the case. The manager told us that they had received a good induction into the service and had been given the opportunity to get to know people and how the service was run. However, the line manager who was supporting them through their probationary period had recently left the organisation. We asked the manager who they were currently receiving support from. They told us that they were unsure as the post was still vacant. They said they had contacted the provider but had not received a response to date due to annual leave.

Although feedback was obtained from people, relatives and other stakeholders regarding the quality of the

service this was not used to ensure continuous improvement. Annual feedback questionnaires were sent to people involved in the service and we observed that comments were largely positive. However, we saw that one person had commented they did not feel they had received appropriate information when moving into the service and a relative had commented they had been concerned regarding the behaviours of some people on occasions. There was no action plan in place to show how these concerns had been responded to.

Failing to complete effective monitoring of the service provided and the lack of support to the registered manager is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events. As reported there had been a number of incidents which involved the police or related to safeguarding concerns. Our records showed that the CQC had not been informed of these incidents to ensure that we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

Staff felt supported and were able to contribute to the running of the service. Records held by the manager showed that staff had received supervision every three months, in line with the providers policy. Staff confirmed this was the case and told us they found the process useful. One staff member told us, "It's our time to talk about anything and look at our development." Regular staff meetings were held and staff told us they felt listened to by the manager. One staff member told us, "We talk about how things need to develop, like more activities for people and people being more involved. If we ask for things the manager makes sure it happens." Meeting minutes confirmed that improvements to the service such as menu's, activities and communication were discussed and staff had the opportunity to contribute.

People were involved in regular group meetings to gain their views on the service. Minutes for one meeting showed that one person had asked for a key for their room, they told us this had been addressed by staff and they were now able to lock their room. Activities had been discussed and people had made suggestions for individual activities including a visit to the zoo and to play bingo. People told us that they had taken part in these activities and enjoyed them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit statutory notification to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks were adequately assessed and had not taken action to mitigate known risks to protect people from harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to implement and use an effective system for protecting people form abuse or harm.

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 ensure effective monitoring of the service provided and had not provided effective support to the registered manager

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure that staff received effective training to carry out their role