Modus Care Limited

The Tobias Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 January and 6 February 2017 both days were unannounced. The service was last inspected on 15 April 2016 when it was rated as 'Good'.

The Tobias Centre is registered to provide accommodation and personal care for up to seven people with learning disabilities and autistic spectrum conditions. On the day of inspection there were six people living at the service.

The service had a registered manager in place. 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.

Prior to this inspection we received concerns that people may be at risk of being unlawfully restrained and having their liberty restricted. There were also concerns relating to risk assessments regarding the use of seclusion and restraint and that staff at the service did not fully understand the terms 'seclusion' and 'restraint'. A report had been prepared by a specialist team from Devon Partnership NHS Trust that outlined their concerns. The findings of this report are being challenged by the provider and the concerns are currently being looked at through the safeguarding processes of the local authority.

Risks associated with people's personal safety or behaviours that may be challenging to others were not always identified. People were not protected from the risks of being unlawfully restrained or restricted. This was because the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS) were not always followed. Records did not demonstrate that required reviews took place regularly or involved others outside of the organisation. Systems were therefore not sufficient or open to ensure or demonstrate that restrictions remained appropriate, safe and lawful.

Systems in place to monitor the quality of care being provided were not always effective. The audits that were in place and visits from the provider's representative had not identified the issues raised by the inspection.

Some aspects of the environment were institutional in appearance and in need of maintenance. The ceiling of one bathroom was mouldy and had a strong smell of damp. The entrance gates were chained together and gave a negative impression of the people living at the service.

Prior to the inspection we spoke with one relative who was not happy with the way their relation was being supported by the service. Following the inspection we spoke with three other relatives. They all told us they were very pleased with the way their relations were supported. Comments from them included "[person's name] is happy there and I would hate to think anyone would move him," and "This is the best placement

he has ever been in."

People were supported to participate in activities inside and outside the service. These included swimming, shopping and going to the pub. People were supported to maintain contact with their families. Wherever possible people and their relatives were involved in making decisions about care provided by staff. Relatives and staff were confident any concerns would be dealt with.

People's needs were met by kind and caring staff. People were not able to tell us about their relationships with staff. However, we saw that people were relaxed and happy in staffs' presence. We observed positive relationships between staff and the people we met at the service. Staff were seen supporting people in an easy, unrushed and pleasant manner. Staff genuinely cared for people's happiness and wellbeing. People were treated as individuals. Staff listened to people and supported them to express their needs and wants. People's abilities varied and staff told us how they encouraged people to be as independent as their abilities allowed.

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

Aspects of the service were not safe.

The service did not always identify and manage risks appropriately.

People were protected by staff who understood how to recognise and report signs of abuse.

There were sufficient numbers of staff to meet people's needs and keep them safe.

People were protected by safe and appropriate systems for handling and administering medicines.

People were protected by safe and robust recruitment practices.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

People were not protected from the risks of being unlawfully restrained or restricted. This was because the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS) were not always followed.

Some aspects of the environment were institutional in appearance.

Staff were knowledgeable and skilled, but not all staff had received training in Autism.

People were supported to have their health and nutritional needs met.

Is the service caring?

Good

The service was caring.

People's needs were met by kind and caring staff.

People's privacy and dignity was respected and all personal care

was provided in private.

Wherever possible people and their relatives were involved in making decisions about care provided by staff.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People received individualised personal care and support as identified in their support plans. However, the plans were not always regularly and thoroughly reviewed and documented.

People were supported to participate in activities inside and outside the service.

Relatives and staff were confident any concerns would be dealt with.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

Systems in place to monitor the quality of care being provided were not always effective.

The service benefitted from having a registered manager that was very open and approachable.

The Tobias Centre

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 was 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 30 January and 6 February 2017 and both days were unannounced.

The first day of the inspection was conducted by two adult social care inspectors and the second day by one adult social care inspector.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the service) sent to us by the registered provider.

The provider had completed a 'Provider information return' and we looked at this information. 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.

During the inspection we met all six people living at Tobias. We also spoke with five staff the registered manager and two social and healthcare professionals. Prior to the inspection we spoke with one relative and following the inspection we spoke with three more relatives.

During the inspection we observed the interaction between staff and people living at the service. We looked at a number of records including four people's care records, the provider's quality assurance system, accident and incident reports, three staff files, records relating to staff training, medicine administration and staffing rotas.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's personal safety or behaviours that may be challenging to others were not always identified. Prior to this inspection we received concerns that people may be at risk of being unlawfully restrained. A report had been prepared by a specialist team from Devon Partnership NHS Trust that outlined their concerns. We looked at the policies and procedures in place regarding seclusion (where people are isolated from others and prevented from leaving) and restraint (where people's movements and their freedom to act independently is restricted) and whether these kept people safe and protected their rights.

The report stated that the terms seclusion and restraint were not properly understood by staff and that this led to incidents not being addressed and recorded correctly. This had also led to people being inappropriately secluded or restrained because the least restrictive option had not been followed. We were told that since the report had been received from the specialist team, the behavioural support advisors for the service had developed a glossary of terminology, which described types of restraint and how they would be used in practice. We found that while staff understood the terms, there had been some confusion as to what actions would be considered secluding a person. We saw from recent incident forms that staff were recording all times seclusion was used. This showed us staff had a better understanding of what seclusion meant.

We also saw that a detailed protocol for the use of seclusion had been drawn up. This highlighted the need to ensure lesser restrictive interventions were used prior to any seclusion. Details of the lesser restrictive practices were outlined in the behavioural support plan. Incident forms showed that staff were attempting more distraction techniques which was less restrictive. The specialist report also stated that when seclusion and restraint was used, recordings were not made appropriately. As part of the review process following recommendations in the report changes had been made to reporting procedures. These included the monitoring of people's well-being and health during periods of seclusion.

For some risks, management plans had been developed to ensure support staff knew how to support people safely and minimise any risks. For example, there were detailed plans in place to minimise risks when people were out walking to the shops and travelling in vehicles.

Assessments had been completed in relation to risks associated with the environment. People had personal evacuation plans in place, which helped ensure their individual needs were known to staff and other services in the event of an emergency. A fire risk assessment was in place, and regular checks undertaken of fire safety equipment. However, we saw that some fire doors were wedged open. The registered manager told us that devices had been ordered to be fitted to the doors that would enable them to be kept open, but close in the event of a fire. The registered manager removed the wedges and assured us the doors would remain closed until the devices were fitted. Staff had received training in first aid and first aid boxes were placed around the service.

People were protected against the risks associated with medicines because the provider had appropriate

arrangements in place to manage medicines. Medicines were stored safely in a locked cupboard in a locked room where people went to receive their medicines. Staff had received training in administering medicines. Medicines Administration Records (MAR) confirmed people had received their medicines as they had been prescribed. Each person had a MAR booklet prepared by Modus which staff completed whenever medicines were administered. All medicines were administered by two members of staff to reduce the risk of errors. There were clear guidelines for when medicines prescribed to be taken 'when required' (PRN) should be administered. No PRN medicines were administered without discussion with and approval by a senior member of staff.

Staff had received training in safeguarding people and knew what to do if they suspected abuse was occurring or had taken place. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies. The registered provider had safeguarding policies and procedures in place. Staff told us they felt confident the registered manager would respond and take appropriate action if they raised concerns.

The registered manager made sure there were enough staff to keep people safe. Staffing levels had been organised for each person dependent on their assessed need. Each person had either one or two staff with them at all times inside or outside the home. During the inspection we saw agreed staffing levels were in place and there were enough staff to support people in different parts of the home. Staff said they felt staffing levels were safe. One staff member said staffing levels were always in place as required and they felt people were rarely unable to go out and do the things they wanted and enjoyed. We were told that sometimes people could not go out as they wished as there was no staff member authorised to drive the vehicles on duty. The registered manager told us this happened rarely and was only when rotas had had to be changed at short notice. We were told agency staff were very rarely used and if this was necessary they would undertake tasks such as cooking and cleaning, and would not work unsupervised with people using the service.

Should someone have an accident or display potentially harmful behaviours, these were recorded. Records showed these events were reviewed by the behavioural support team. However, while the incidents themselves were reviewed the root cause of the incident did not appear to always have been fully identified. For example, one review had failed to identify an incident had occurred because staff had not followed a specific routine for one person. We discussed the way reviews were conducted with members of the behavioural support team and the process was to be made more robust and review all aspects of incidents.

There were robust recruitment systems in place. This protected people from the risks associated with employing staff who may be unsuitable to work in care. Staff histories were checked to ensure they were suitable to work at the service. These checks included seeking references from previous employers, obtaining a full employment history and checking with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People living at Tobias House had needs associated with a learning disability, autism and Aspergers syndrome. These needs may affect their ability to make decisions for themselves.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had obtained DoLS authorisations for people when continuous supervision was required. We were told six DoLS authorisations were in place one of which had been re-applied for, as it was due for renewal.

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.

Positive Behaviour Support (PBS) plans had been developed for some people who could at times, display behaviours which could place them or others at risk of harm. The PBM plan also included guidelines for staff about the use of physical intervention and how and when these may need to be used. The types of physical interventions used included 'assisted support', 'two person removal', 'seated restraint' and 'supine restraint'. The specialist team report stated that staff at the service only recorded 'seated restraint' and 'supine restraint' as restraint. While physical interventions were being recorded they were not recorded as 'restraint'. Since the report was received all physical interventions were being recorded as the use of restraint.

We looked at the plans for four people who used the service. One of the plans we looked at included the use of a room for the person to be taken to when their behaviour escalated to a crisis. The authorised DoLS for this person detailed information about this restrictive practice. It also stated that family and other agencies must be regularly consulted and involved as part of the review process for this person. Records did not demonstrate that these reviews took place regularly or involved others outside of the organisation. Systems were therefore not sufficient or open to ensure or demonstrate that restrictions remained appropriate, safe and lawful.

We saw that the plans for two people to manage behaviours included the use of separate rooms, referred to in reports and support plans as an SWA (Supported Withdrawal Area). A 'stable' type door had been fitted to the entrance of both of these rooms. One of the rooms had a lock fitted on the stable door and guidelines were in place for when staff could leave the room and lock the bottom half of the door. Staff said the person was able to reach over and unlock the door if they wanted. However, staff described a three stage calming plan, which involved the person sitting on a chair, moving to another chair and calming before be able to leave. We were initially told by a behavioural support advisor the person would sometimes just choose to go to this room, even when there had not been an incident. However, support staff we spoke with said it was only used to manage the person's behaviours. When looking at incident forms it appeared this SWA had become a negative area for the person where a certain pattern of behaviour was expected to occur before they could leave the room. A further report by the specialist team highlighted this procedure was not always the least restrictive measure that could be used. The report stated avoiding obvious triggers known to

escalate behaviours or re-directive methods would be less restrictive.

Staff were familiar with the guidelines for the use of both SWAs and they were seen as rooms where people's heightened behaviour was reduced. Staff did not see either room as a restriction or seclusion as they told us people could leave if they wanted to. However, there were no regular reviews of the use of either room to ensure the use of the rooms remained appropriate, safe and lawful. The continuing use of this method of managing people's behaviour suggested the environment was not appropriate and was potentially overly restrictive.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the environment and spoke with staff about any restrictions or restrictive practice within the service. We were aware that concerns had been raised regarding the use of restraint and seclusion. The local authority safeguarding team were in the process of investigating these concerns and a report had been prepared by specialist advisors. The behavioural support advisors told us they had received a copy of the report and had reviewed their practice in line with the recommendations made. This had included reviewing and updating seclusion and restraint protocols to ensure people remained safe and protected at all times.

We saw that when an incident occurred an 'event' form was completed. If environmental restriction or physical restraint was used an additional form was completed as part of the recording and reporting process. We looked at two recent incidents one of which had included the use of physical restraint. A detailed account was provided by staff of events leading to the incident, action taken by staff to de-escalate and protect the person and others, and the action taken when the incident escalated to a crisis. We saw forms had been completed by staff as required.

Parts of the service, such as the hallway and people's personal space were sparse and poorly decorated. We were told that some people due to their needs required their personal space to be sparse, with minimal personal possessions. This was because too many furnishings could be unsafe or make the person anxious. However, this need for minimal furnishings was not documented as part of people's support plans. This could mean people's environmental needs were not regularly reviewed to ensure they remained appropriate. When people required minimal amounts of furnishings and personal belongings, little consideration had been given to the use of colours and lighting to make the environment homely, relaxing and stimulating.

Some areas of the service had an institutional appearance, especially those areas that had been adapted to maintain people's safety. The stable doors were of an institutional type. A visiting professional said when they had arrived the large chain on the front gate had given them a negative perception of the people who may live in the home.

The kitchen door was kept locked, but staff said people were able to use the kitchen when supported by staff. We saw drinks were passed out through a small hatch in the kitchen wall to the hall area. Due to the size of the hatch people were not able to see the staff who were passing them the drinks or engage with them when drinks were being provided. This again gave the environment an institutionalised feel, and was pointed out to staff at the time of the inspection. Following the inspection the provider wrote and told us they felt the removal of this hatch would have a negative effect on some of the people living at the service.

Parts of the home were poorly maintained. For example, one person's bedroom had extensive damage to the wall. There was no evidence of a plan in place to address this damage, which from the extent of it had

been present for some time. One person's bathroom had a significant amount of damp on the ceiling, which was causing an offensive smell within the room and hallway. The registered manager showed us evidence of several emails sent to the provider asking for these items to be addressed.

This was a breach of Regulation 15 (1)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Some staff had undertaken MCA and DoLS refresher training the week prior to the inspection.

Daily records and observations provided some evidence that where possible people were supported to make decisions about their care and lifestyle. Mental capacity assessments had been completed in relation to some aspects of people's care and lifestyle, such as their capacity to manage medicines, personal finances and to decide whether to remain living in the home. There had been no mental capacity assessments or best interest meetings undertaken in regard to the use of restraint or seclusion. We discussed with staff the need to consider people's capacity in relation to all aspects of their care and lifestyle and these assessments should be reflected within people's support plans to help ensure people's rights, choices and control was promoted and respected at all times.

Staff said they felt well supported by management and the staff team. One staff member said "I always feel very well supported, there is always someone we can speak to and ask for support" and "I have had regular supervision and training as part of my induction". Records showed staff received regular supervision and appraisals.

There was a comprehensive staff training programme in place and a system to indicate when updates were needed. Staff had received a variety of training such as medicine administration, first aid and infection control. Staff also had the opportunity to undertake training specific to the needs of people they supported. For example, staff had undertaken training in Makaton and British Sign Language (both types of sign language). This helped them to better support and understand the needs of people who had a sensory impairment. One person was fluent in sign language and staff involved them in training new staff.

We saw that not all staff had received training in Autism. One staff member told us they had worked at the service for almost a year and had not received any such training. We found this particularly concerning as the Modus care website describes Tobias House as an 'Autism & Aspergers Syndrome Residential Care Home'. However, we saw that some training in Autism was due to take place on 13 February 2017.

On the first day of inspection two behavioural support advisors employed by the organisation were working in the service. They told us they provided advice and staff training in supporting people's communication and behaviour. They also developed and reviewed behaviour management plans in relation to the techniques, methods and guidelines used to manage people's behaviours that may put them or others at risk of harm or injury. One of the advisors provided Positive Behavioural Management (PBM) training to staff. We were told the PBM training provided to staff was BILD (British Institute of Learning Disability) accredited, and the behavioural support advisors regularly received training to keep them updated. One staff member said "It is the policy that staff do not even start working in the home until they have completed their PBM training."

People were supported to have sufficient to eat, drink and maintain a balanced diet. People were asked what they would like to eat and were supported to prepare meals, where their abilities allowed. On the second day of inspection lunch was sandwiches. A large variety of fillings were taken into the dining area and people were helped to prepare their chosen sandwich. The main meal of the day was during the evening and was prepared by a chef. Staff knew people's preferences and the menus were drawn up taking these into account.

People were supported to maintain good health and had access to healthcare services where required. Records showed people had seen their GP when they needed to and also for an annual health check. Records showed details of any healthcare specialists involved in people's care. For example, speech and language therapists, dentists and podiatrists had all been involved with people's healthcare needs.
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Good

Is the service caring?

Our findings

People were not able to tell us about their relationships with staff. However, we saw that people were relaxed and happy in staffs' presence. We observed positive relationships between staff and the people we met at the service. Staff were seen supporting people in an easy, unrushed and pleasant manner.

Prior to the inspection we spoke with one relative who was not happy with the way their relation was being supported by the service. Following the inspection we spoke with three other relatives. They all told us they were very pleased with the way their relations were supported. Comments from them included "[person's name] is happy there and I would hate to think anyone would move him," and "This is the best placement he has ever been in."

Staff demonstrated they knew the people they supported. They were able to tell us about people's preferences and personal histories. For example, staff knew what people liked to eat, what they liked to do and when they liked to get up and go to bed. Staff told us one person particularly enjoyed regular hot drinks. They told us the person always "Savours a cup of tea." Staff told us about one person who had been anxious when they had first woken that morning. The staff described the method they had used to reduce the person's anxiety and told us the person was now looking forward to going out for the afternoon.

People living at Tobias House had different methods of communication. Staff knew each person's particular method and could understand people's needs and requests. One person was particularly skilled in the use of sign language and they helped teach new staff how to sign. The person had dedicated time each hour for staff to spend signing with them. Staff helped us understand a series of questions the person liked to ask all visitors to the service.

Staff treated people with respect and kindness. For example, staff addressed people by their preferred names, showed physical affection and spoke with respect. People's privacy was respected. Staff took care to ensure people's appearance was clean and tidy and that their hair was combed. Staff spoke discreetly with people when asking them if they needed help with personal care. All personal care was provided in private and staff said they always ensured doors were closed when helping with personal care.

Staff genuinely cared for people's happiness and wellbeing. People were treated as individuals. Staff listened to people and supported them to express their needs and wants. People's abilities varied and staff told us how they encouraged people to be as independent as their abilities allowed.

People were not always able to be actively involved in planning their care. However, staff knew people well and when planning care, took into account what they knew about the person and their preferences. Staff told us they involved people as much as they could. People's relatives could be involved in planning people's care when they wished to be. Three relatives we spoke with told us they were kept fully informed about all aspects of their relation's care. For example, people were supported to prepare meals.

Requires Improvement

Is the service responsive?

Our findings

While people received individualised personal care and support as identified in their support plans, the plans were not always regularly and thoroughly reviewed. Where reviews had taken place actions were not always followed through. For example, we spoke with one social care professional who told us that a review in 2015 for one person had highlighted a need to review their staffing levels when out in the community. They found at their visit in January 2017 that the provider had not undertaken this review. The social care professional also felt that two staff supporting the person in the community could potentially be restrictive for the person if this was not required. The provider had since given assurance the review would be undertaken. The social care professional also found that the person did not always receive the four hours support outside the service they had commissioned. The provider said the person did not always want to go out, but this was not always recorded.

We discussed with a behavioural support advisor for the organisation that it would be good practice when planning staffing levels, training needs and qualities of the staff team to include information about people's needs. This would further evidence personalised care and planning was being provided.

We found that care records for people were large documents with some repeated information. Some records were difficult to access. This may in part, have been due to a change from paper records to an electronic system. A social care professional told us they had had similar difficulties when trying to obtain information. However, they said staff had been helpful to them when reviewing the documents.

Positive Behaviour Management (PBM) plans had been developed for some people who could at times, display behaviours which could place them or others at risk of harm. We looked at the plans for four people who used the service. We saw these plans described the person and the types of behaviours they could display and how these behaviours could affect them and others. The plans included a detailed account of the possible triggers for behaviours and how staff could support the person to prevent the behaviours occurring. The plan also described in the form of a 'traffic light' system the action staff needed to take if the person's behaviour started to escalate. A focus throughout the plan was for staff to de-escalate the situation by knowing the person and using the least restrictive methods possible through PBM.

We saw Positive Behavioural Support (PBS) plans were reviewed on a three monthly basis by a behavioural support advisor for the service. We asked about the process and were told that the current plan was looked at to see if any changes had occurred or were needed and any necessary amendments were made. However, this review process was not documented, therefore it was not possible to see if and when other agencies and or their families were consulted and involved in this process.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of people's support plans and knew how to support people on a day to day basis. They were also able to describe how to recognise when people were becoming anxious and what they would do

to help prevent them from becoming more anxious. For example, staff told us how suggesting a foot massage to one person would help reduce their anxiety. Staff spoke positively about the people they supported. They told us about how everyone was treated as an individual as they all had different support needs.

People were supported to maintain contact with people who were important to them. People regularly visited relatives or kept in touch with them over the telephone.

Everyone living at the service needed support from staff to plan their day and occupy their time. Each person had a documented plan for the day, which was used to help ensure staffing levels were sufficient. People were generally able to go out and about as they chose. We saw people went swimming, shopping for a coffee or to the pub. Two people had their own transport and two company vehicles were also available to take people out.

We saw that one person went out to the shops each day to make purchases or to post letters. Another person liked to go swimming and staff told us how they supported them to get ready to go out. There was a range of games and activities for people to take part in within the service. Staff told us they used these to help occupy and distract people throughout the day. Staff told us how one person enjoyed finding building blocks staff had hidden around the service. One person spent 15 minutes each hour signing with staff.

Staff told us that while they had a duty of care to support people they also promoted people's independence. They told us how they supported one person who had sensory difficulties, make a cup of tea for themselves by giving them a jug of hot water a jug of milk, a tea bag and a mug on a tray. The person could then make the drink themselves.

A complaints policy and procedure was available and outlined clearly the action the service would take in response to complaints and the timescale for investigating them. The registered manager said the service had received one verbal complaint from a neighbour about noise coming from the service. This had been dealt with satisfactorily and there had been no further complaints. Staff told us people would not be able to use a written complaints process, but were confident they would recognise if people were unhappy about anything. Three relatives told us they had never had to make a complaint and felt their relations were happy at the service. One relative told us "I would know if he wasn't happy."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager employed at the service. A deputy manager who had supported them in their role had recently left and the registered manager was looking to appoint another person to this role. A representative of the provider regularly visited the service and the registered manager told us they felt well supported by them. However, their visits had failed to identify the issues raised during this inspection.

There were some systems in place to assess, monitor, and improve the quality and safety of care. A series of audits were undertaken. These audits included looking at medicines, support plans, the environment and equipment. Where some issues had been identified action had been taken to rectify matters. For example, automatic fire door closures had been ordered to prevent fire doors being wedged open.

However, the systems were not entirely effective. Not all issues identified during this inspection had been identified through the audit process. For example, audits of support plans only checked they contained the required information. They did not ensure the support being provided was appropriate. Not all incidents were reviewed to look at the root cause. Not all reviews were recorded. Deprivation of Liberty safeguards had been authorised. However, practices within the service which could restrict people, were not reviewed regularly to ensure they remained appropriate and lawful. Issues that had been identified such as the need for a bathroom and bedroom to be properly maintained had not been addressed by the provider.

We were told by a behavioural support advisor for the service that since receiving the report from the specialist team the provider had liaised closely with all relevant agencies and met on a weekly basis to discuss practice issues. However, the service's lack of a clear, documented review process, does not demonstrate multi-agency joint working and openness.

In their 'Provider Information Return' submitted in January 2016 the provider told us they planned to liaise "with relevant professionals that specialise in communication to be able to help identify some quality assurance systems to use with our complex service user group." During the inspection we saw no evidence that this had been completed.

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

The registered manager was at the service for the second day of the inspection. They told us they had been surprised by the recent report by the specialist team as the issues identified in the report had not been previously identified by other visiting professionals. They told us they were working closely with the specialist team to address the issues.

The registered manager and staff were committed to providing high quality care. Staff spoke passionately about their work and wanted to improve the quality of people's lives. They told us staff had "genuine empathy" with the people they supported and promoted their independence as much as their abilities allowed.

Prior to our inspection in April 2016 the service had sent out surveys to obtain the views of people's representatives. The registered manager told us these were sent out annually and none had been sent out yet this year. Staff told us they always tried to obtain people's views and felt they would know if someone was unhappy and would then involve the registered manager to find out how to help them.

Staff told us there was an open culture at the home, where any issues were discussed and dealt with. Staff said no-one had any fear of reporting anything untoward. Staff told us they felt well supported by the registered manager and could go to them for advice at any time. They said staff meetings were held regularly when they could discuss any issues. Staff felt able to make suggestions for improvements. One staff member told us they had suggested one person would benefit from visiting the 'wave' swimming pool. This had been implemented with good effect.

The registered manager told us they kept their knowledge of care management and legislation up to date by attending regular training sessions and provider forums.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager understood their legal obligations including the conditions of their registration. They had correctly notified us of any significant incidents and had shared their response and plans for improvement to reduce the likelihood of reoccurrence.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not regularly monitored and reviewed their approach to and the use of restraint and restrictive practices. Regulation 13 (4)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not properly maintained or suitable for the purpose for which they were being used. Regulation 15 (1)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to effectively assess, monitor and improve the quality and safety of the services provided. Regulation 17.