Cintre Community Limited

Severn Oaks

Inspection report

6 Jesmond Road
Clevedon
Somerset
BS21 7SA

Tel: 01275878447
Website: www.cintre.org

Date of inspection visit:
23 February 2016
01 March 2016

Date of publication:
24 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Severn Oaks provides accommodation for up to seven people who have complex needs including medical issues, learning disabilities, autism spectrum disorders and mental health. Most people living at the home have communication difficulties and find it difficult to speak with new people. On the day of inspection there were six people living at the home. The accommodation was arranged over three floors and a basement. On the ground floor there were a number of communal spaces including a pool room and lounge. In the basement there was a laundry room and woodwork workshop.

This inspection was unannounced and took place on 23 February and 1 March 2016.

The registered manager has been in post for nine-months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe but we found there were risks to their safety. There were concerns about the medication procedures in the home. Medicines taken "as required" rather than regularly did not have written protocols for staff to follow, medicines taken out of the home were not always signed back in and the provider did not have safe systems in place to ensure when people brought over the counter medicines into the home they were informed.

Staff told us there were enough staff to support people. Most staff had been working at the home for a long period of time. The recruitment process followed good practice and the registered manager was reviewing whether they would keep copies of staff files on site as well as in the head office so they were more accessible. Staff told us they had comprehensive induction and training and there was good understanding of how to support people using their training.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home or the provider and they knew whom to contact externally. The registered manager understood when they were responsible for informing the local authority and CQC about safeguarding.

Staff and the registered manager had some understanding about people who lacked capacity to make decisions for themselves. Some people potentially had fluctuating capacity because of their diagnosis and complex needs but the Mental Capacity Act Code of Practice had not been followed when people's capacity was in question.. The consultation process, when people lacked capacity, had not been clearly documented in care plans and the plans also weren't clear if people had decision specific two part assessments. Staff understood about Deprivation of Liberty Safeguards and what process to follow if someone in the home required this.

There were some quality assurance procedures in place to keep people safe. When shortfalls had been identified by the local authority the home had rectified the concerns. However, the registered manager and provider only had some systems in place to identify shortfalls and demonstrate proactive management; these had not picked up all the concerns we found.

Staff supported people to see a wide range of health and social care professionals to help with their care; this was important because many people had complex needs. Staff supported and respected the choices made by people. People's cultural and religious differences were respected.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. If people expressed they wanted to help with the cooking then this was supported. Staff encouraged people to follow a healthy diet in a caring and respectful way.

People and their relatives thought the staff were kind and caring and we observed positive interactions. The privacy and dignity of people was respected and people were encouraged to make choices throughout their day.

There were detailed care plans for all individuals including religious and cultural information. These plans had a person centred approach to them and captured the people's voice. This meant people were central to their care and any decisions made. The needs of the people were reflected within the plans; they were responsive to people's changes. Staff had good knowledge about the care plans.

People knew how to complain and there were good systems in place to manage the complaints. Easy read complaint forms were available for the people in their care plans. The registered manager demonstrated a good understanding of how to respond to complaints.

The registered manager and provider had a clear vision for the home and had some systems in place to communicate this.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medication was not always managed following best practice.

Staff understood how to keep people safe and who to tell if they had concerns about people's safety.

Risks of abuse to people were minimised because there was an effective recruitment procedure for new staff

There were enough staff to meet the needs of the people that used the service.

Is the service effective?

Requires Improvement

The home was not always effective.

People with fluctuating capacity did not always have the correct process followed to help with important decisions. The registered manager and staff demonstrated understanding about making best interest decisions on behalf of someone who did not have capacity

People were supported by staff who had induction and training to meet their needs.

People were supported appropriately to eat and drink. They participated in cooking and preparation of meals.

There was contact and access to other health and social care professionals to make sure people's needs were met.

Is the service caring?

Good

This service was caring.

People told us that they were well looked after and we saw that the staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected.

People's cultural and religious needs were considered at all times.

Is the service responsive?

Good

The service was responsive

People's voices were captured in their care plans.

People participated in activities that were personalised to their interests, needs and cultural differences.

People did receive care and support in line with care plans and staff were familiar with them.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had some quality assurance systems in place but they did not identify some of the shortfalls we found.

People, staff and health and social care professionals were positive about the management of the home.

The registered manager and provider had a vision for the home and staff were well supported.

The registered manager kept their knowledge and skills up to date so they could provide the right support for people.

Severn Oaks

Detailed findings

Background to this inspection

Start this section with the following sentence:

'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.'

Say when the inspection took place and be very clear about whether the inspection was announced or unannounced, for example by saying:

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 23 February and 1 March 2016 and was unannounced. It was carried out by two adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We spoke with three people that lived at the home in detail and had informal chats with other people at the home. We spoke with the registered manager and five members of staff. On the telephone, we spoke with one relative and three health and social care professionals.

We looked at four people's care records and observed care and support in communal areas. We looked at five staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints file, staff and resident meeting minutes, medication files, environmental files and a selection of

the provider's policies.

Requires Improvement

Is the service safe?

Our findings

The home was not always safe because there were concerns around medicine management. People's medicines were administered by staff who undertook medication training before they became authorised to handle medicine. However, six of the nine authorised staff were overdue a revision in their medication training. The registered manager told us they had been booked to attend training in December 2015 but this had been cancelled due to illness of the trainer. Between the two days of inspection the registered manager had completed a train the trainer course for medication; this meant they were now able to train the other staff in medication and complete their overdue updates. During the inspection the registered manager made arrangements to deliver training to all staff at the home.

Some people were prescribed medicines on an 'as required' basis. This meant the medicine was only taken when the person needed it. Written protocols were not in place so staff would know how or when to deliver this medicine. So staff are aware of how and when to deliver this medicine there should be written protocols. One person had an "as required" medicine due to their medical condition. A protocol had been started in November 2014 before the medicine had been used. The protocol said it needed to be updated to record how the person responded to the medicine; it had not been updated despite the medicine being used. Another person had an "as required medicine" to help them when they became agitated. There was no information available for staff about how or when this medicine should be used. We spoke to the registered manager who explained it is a small staff team and they "just know if [the person] is becoming more agitated". If no regular staff are available or there is a new member of staff they would not know when to administer each medicine. It would also help to ensure the consistency and safety of usage by members of staff.

We checked medicine records against stocks held and found them to be correct except for one "as required" medicine. The person had visited their family with three doses. Whilst away they had used two doses, so returned to the home with one dose. There was no record on the use of the doses whilst the person was away neither had the returned dose been signed back in. This meant there was a chance medicines could go missing when people are staying away from the home and they would be not be able to account for all the medicines. There was a system in place where they should have signed the medicine back into the home.

Two people living at the home were self-medicating. This means they were taking control of administering their own medicines. Both people had completed risk assessments and procedures in place. However, the procedures were not fully adhered to. For example, the procedures stated when people who self-medicate purchase homely remedies they had to inform staff; this process had not been followed by the home. Homely remedies are medicines which can be bought from local shops or pharmacies over the counter without a prescription. In order to reduce risks to people there were risk assessments and procedures had been put in place By not following them staff would be less able to monitor people's use of homely remedies and keep them safe.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable secure storage facilities for medicines. The home used a blister pack system with printed medication administration records. We saw medication administration records and noted most medicines entering the home from the pharmacy were recorded when received and when administered or refused. This was meant to give a clear audit trail and should have provided systems for staff to know what medicines were on the premises. Even though the home had no people who required medicines which required additional security and recording we saw the home was prepared as they had storage and recording systems in place.

Care plans contained risks assessments which outlined measures in place to enable people to take part in activities with minimum risk to themselves. One health and social care professional explained the home followed "Good positive risk taking". They explained that although the person had substantial risks posed by a medical condition, calculated risks including going out in the community independently occurred. However, when risks were identified with people the home had not always considered risks to others. For example, one person with significant medical needs had a risk assessment in place for the use of a bike unsupervised. This included risks to them as an individual but by using this on or near the road there was a chance of an accident involving members of the public which the home had not taken into account.

People told us they felt safe at the home and with the staff who supported them. When people were asked if the home kept them safe they said, "Yeah" and "Yeah, they keep me safe". When a relative was asked if the home keeps their loved one safe they said, "Yes. As far as [they] can ever be safe". Health and social care professionals said the home "Certainly appears safe" and "People are safe".

Staff told us, and records seen confirmed all staff received training in how to recognise and report abuse. Staff spoken with had an understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Risks of abuse to people were minimised because there was an effective recruitment procedure for new staff. Staff we spoke with confirmed they had the correct checks including a Disclosure and Barring Service (DBS) check. A DBS check is to make sure staff do not have a criminal record and do not appear on a special list to protect vulnerable adults. All staff files were kept centrally in the head office which meant the registered manager was unable to check the files regularly. The registered manager was reviewing this situation to see if it was possible to keep a copy of staff files on site for their own reference. The home's recruitment policy stated each person should have at least two references and this was the case for all staff.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. Most staff thought the staffing levels were about right. One staff member said "Staff levels are sufficient". Another staff member said, "I think a nice small team is good" but explained the positives of having new members of staff join the team. A third member of staff told us the home used to use agency staff and said, "Now we all kind of chip in". Many of the staff members had been working at the home for a long time.

Requires Improvement

Is the service effective?

Our findings

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

We checked whether the service was working within the principles of the MCA. Staff members were able to speak with us about the MCA and the principles which needed to be followed. The registered manager told us all people currently living at the home had full capacity and so the principals of the MCA code of practice were not required. However, the MCA recognises some people will have fluctuating capacity regarding some decisions. For one person living at the home a relative and a health and social care professional said fluctuating capacity was a possibility for the person. There were comments within this person's risk assessment about entering the community alone may put others at risk. No two-part capacity assessment had been completed in relation to this decision. A two-part capacity assessment is part of the MCA Code of Practice to determine whether a person has the understanding to make a specific decision. The home had made sure this person regularly phones them for an update as they were entering the community alone.

People had documented medical and complex needs which are known to cause fluctuating capacity in some cases. The home had not considered the possibility they may lack capacity over health and welfare decisions. This could place them at risk because they may not understood the long term impact of such decisions. For example, one person who had a specific medical condition had been advised to wear a head protector and a special wrist band which interacted with a device placed in their body. The use of a pressure mat had been suggested so sleep-in staff could be alerted to any abnormal movement the person made. It had been documented in the person's care plan they had chosen to abandon all three of these protective measures. There were risk assessments and conversations with staff indicating the person may not have full understanding of the consequences to this decision which meant their capacity would be in doubt. The MCA code of practice had not been followed in this circumstance.

Another person had debt collectors trying to recover money they owed for a large purchase they had made. The person stopped making the necessary payments because they did not want to. The registered manager explained due to this person's additional needs they were impulsive with money but had a good understanding of maths. Their risk assessment for finances and debt said "[Person's name] is competent in using the computer and will set up direct debits online not realising the implications of the money which will be taken from [their] bank account, nor the charges [they] will incur as a result of insufficient funds in [their] account." Therefore, this person is at risk of financial difficulties because of their lack of understanding and capacity around managing money which the home had not followed up on. A member of staff said "Up until today I thought [person's name] had capacity". The MCA code of practice had not been followed to assess this person's capacity about managing money.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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). We checked whether any conditions on authorisations to deprive a person of their liberty were being met.

All staff we spoke with had an understanding of DoLS. One member of staff told us that a person who used to live at the home had been subject to DoLS, but currently there was no one. Members of staff and the registered manager explained the home operated an open door policy. During the inspection we saw people choosing to go into the community independently or, if they chose, with support.

People received effective care and support from staff who had the skills and knowledge to meet their needs. Staff we spoke with were generally happy with the training they had received since working at the home. One staff member said "The thing I like most is the training". Another member of staff explained they were given enough skills to do their job. A third member of staff explained training was picking back up with the new registered manager, but they did not enjoy the online mandatory training. There had been issues with organised training being cancelled due to unforeseen circumstances but the registered manager had been finding solutions. For example, the medication training was cancelled but the registered manager has now become a train the trainer and would deliver it themselves.

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. Staff told us they received regular supervision and appraisal. One staff member said, "Yes I think [supervision] is useful – even if it's just to say yes, you're doing a good job". We were told the company had a policy that staff supervisions should be regular. The registered manager was trying to make sure everyone was supervised every six weeks. We were also told more informal conversations could be written up as supervision when relevant. The registered manager and deputy manager had introduced a compassion fatigue self-assessment as part of their supervisions. This was a tool being used to monitor how staff were feeling and whether there were ways the management and provider could help them if they were not feeling positive.

People were able to choose what they wanted to eat. One person when asked about the food at the home said, "I like it. It is good. Quite variable". Another person told us about his favourite food which was cheesy mash and toad in the hole. A staff member told us the home did not have a planned menu because this did not work for those who lived at the home. On the first day of the inspection at lunchtime the home had created a buffet for people to help themselves. There was a selection of salad, meat, quiche and cheese for people to pick from. A member of staff explained they like to do this regularly and the people participating enjoyed the spread of food.

Staff tried to encourage healthy eating and found if they cooked a healthy meal in the late afternoon often people would choose that rather than cook a less healthy option for themselves. Recently, the home had started to monitor what was provided in a kitchen diary. We saw a number of things being prepared in the kitchen including cakes and toad in the hole with cheesy mash. On the second day of our inspection the people and staff told us about a lasagne bake-off between a member of staff and a person living at the home.

There was no one on a special diet although one person was receiving specialist support from a dietician about developing healthier eating habits. This was following an annual health check which had revealed a tendency towards diet related health problems. The person was being supported appropriately to seek a

healthier version of their favourite drink. Another person had a cultural difference with dietary requirements in order to meet their religious beliefs. Staff were aware of this and assisted them to make choices in line with their religion.

The home had positive links with other health and social care professionals to meet the needs of individuals. A health and social care professional said the home "Seeks advice appropriately". People had the opportunity to see doctors, dieticians, opticians and dentists. During our inspection we saw one person choosing which member of staff would accompany them to a doctor's appointment for an annual health check. Another person required an emergency dentist which the registered manager and staff arranged for them.

We saw staff at the home using guidance from other health and social care professionals to enhance the well-being of the people living there. For example, one person who had the potential for weight related issues was being encouraged to attend the gym on a regular basis. The registered manager had sought advice from specialist when people had displayed a change in behaviour which required additional support.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. One person said the staff were, "Really supportive". Another person explained when something upsetting happened on television and they cried staff would support them and "Comfort me". When we spoke to a relative about the staff they said, "I think they are kindly in the main". A health and social care professional said the home gave "Very good care". Whilst we were speaking to a member of staff the phone rang several times; they explained "The guys call a lot when they are out, which I think is nice. It's like phoning Mum and checking in".

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. For example, a member of staff sat with a person and completed a "My view of the week" document. The paperwork had been developed by the home so people could reflect on their week including how they had behaved towards others. The person explained they appreciated it because they wanted to tell friends at their church how they had been. Others chose to complete the document by talking through their answers with a member of staff rather than filling it in. A member of staff told us it was a good way to find out how each person was. Staff used discussions whilst cooking or playing games of pool as more informal methods of speaking through issues with people and exploring their care.

People's privacy was respected and staff explained they would only enter rooms with permission. We asked what staff would do if someone's bedroom was becoming an issue because it was not being looked after and cleaned. We were told everyone has a weekly room-care day where their key-worker would advise and assist in tidying and cleaning the room. Staff said, "They [the people] are always keen for us to go in as we're helpful!"

Each person had a single room and had a key to their bedroom. People were allowed to personalise their bedroom. Not only could they personalise their own room but they contributed to the décor in the rest of the house. For example, in the pool room they had designed and made the ceiling rigging and chose the scheme. The people had cut the wood for this room in their woodwork room. We were told by the registered manager one day some of the people had decided to change the colour of the hallway so they went out bought the paint and re-painted it.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas or pool room so spent time in their rooms. Other people chose to go out in the community with their friends. The home supported them to make these choices and facilitated them where possible. There were monthly house meetings where discussions occurred and people could express their views. For example, one person explained they wanted to have a more active role in cooking meals; during the inspection this person was seen involved in meal preparation and making a cake.

Staff respected people's cultural and religious differences. One person told us staff give them lifts to church and supported them to attend a Bible studies group. Staff were able to tell us about another person who is from a different cultural background to their own and their dietary differences. A third person chose an

alternative way of dressing. A member of staff had supported them with these choices and provided them with information and guidance when required.

In people's care plans there were easy read end of life plans. These had been personalised to each individual and the people had their cultural and religious needs considered in the decisions. For example, one person had a signed end of life conversation which said "I have my ashes scattered on the green in [name of place], I played football there as a child". It continued to say they wanted a non-religious ceremony.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. During house meetings the importance of confidentiality was discussed with people living at the home including why the office door had to be shut during certain conversations. It was clear staff had an in depth knowledge of people including their history and preferences in order to provide care and support which met their needs.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. People were able to make choices about all aspects of their day to day lives. One person told us they "Can do stuff like cinema and go karting" they continued to say "At the moment there is an idea to go on a house holiday in a group". A member of staff confirmed this person was doing the research for the holiday. Another member of staff said, "The guys come and go as they please. We do ask if they can tell us when they go out (in case of fire)".

The care plans captured the voice of the person and when possible people signed off each section to show they agreed. For example, one care plan had statements from the person such as "I love playing football and playing pool. I can kick the ball really hard"; the person regularly went to football and participated in pool tournaments in the house. In another care plan it said, "There is no way I'm going to the dentist, not on your life. I hate them". Staff explained if the person communicated pain to them they would seek out a dentist for them; this was an agreed alternative by the person because they did not want to regularly see the dentist. Another person's care plan said, "I really enjoy pizza and burgers and chips"; staff knew about their food preferences.

Care plans reflected people's cultural and religious differences. One person's care plan said "[Name of person] has recently identified some other [country of origin] people in the local community. This is important as it solidifies [their] cultural identity". Staff confirmed this person was encouraged to speak with staff about what is important to them. The person was teaching members of staff to say 'hello' in their first language which was not English.

People were encouraged to participate in the wider local community life. One person we spoke with told us they did volunteering work at a location charity shop and were active in their church. Another person had a timesheet for the work they had attended. Staff were able to tell us about the details of each person which was in line with their care plan.

The staff responded to changes in people's needs. People had conversation records in their care plans which were designed to record any concerns they raised. These notes showed how staff followed up on issues and how they had supported the person through their day-to-day concerns. The registered manager explained following recent training for staff about autism and mental health it had made them consider a different format for recording changes in behaviour. They wanted to introduce these special forms so patterns of behaviour and possible triggers could be monitored so changes to their support could be made.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. The home involved a wide range of health and social care professionals when making decisions about whether they could meet the needs of a person. A person who had recently moved in the home already had a detailed front page about their personal information and a pen profile. This meant staff had information they could refer to in order to support the person in line with their needs and preferences.

People were supported to maintain contact with friends and family. One person was being supported by an advocate. An advocate is an independent person who acts as the voice for a person who struggles to communicate their needs and wishes. This meant there was a separate person they could speak with if they were having trouble communicating their feelings to a member of staff or their relative.

The registered manager sought people's feedback and took action to address issues raised. There was an annual survey allowing the people, relatives, staff and other professionals to provide their feedback on the home. The staff and people also had regular meetings to provide feedback about the home and to have information shared with them. One of the recent staff meetings had the provider attending to share visions of the company for the future and gave staff the opportunity to ask questions.

People we spoke with knew how to make complaints. One person explained they knew how to make a complaint; they said, "When I was stressed I made a complaint". Another person said, "I've asked for toad in the hole and cheesy mash to be cooked more often. It hasn't happened". A member of staff explained they have it every week but we "Draw the line at three or four times a week". They continued to explain the person could make a small portion for themselves. The person laughed in agreement when this was said. This meant staff listened to the people and their complaints but provided clear explanations when changes being asked for would not be made.

People had copies of a visual, easy read complaints form in their care plan. The registered manager explained most of the complaints were from the people and resolved informally. In the complaints and complements file the registered manager had kept an audit of all complaints and a monthly summary of them. There had been complaints in February, March, July and October 2015. In each case the registered manager had recorded the date, nature of the complaint and the response. The complainant was asked to sign the complaint off with a note of their satisfaction or otherwise. All complaints had been managed in an efficient and timely manner in line with the company's policy.

Requires Improvement

Is the service well-led?

Our findings

The home was not always well led because quality assurance systems were not always in place and the registered manager said they had not considered peoples mental capacity at times when they had made important decisions. Some weekly and monthly checks were in place which ensured the safety of people including vehicle checks and fire systems. However, not all audits and checks were in place to monitor safety and quality of care. For example, some people's care plans had not had their monthly reviews from their key workers since the beginning of 2016. We spoke to the registered manager who said there was not a formal system in place for checking every care plan and admitted they may have missed some. In addition, the failures around the management and administration of medicines we found had not been identified by the registered manager. Recent training they had attended was going to help them review systems around managing medicines.

We saw where shortfalls in the service had been identified action had been taken to improve practice. Recently, there had been a visit from the local authority that identified actions which were required. The registered manager was already working on the actions and we could see the improvements being made. However, there was no whole home action plan to identify areas of development the provider and registered manager had identified. This meant the home was being reactive to what others were telling them rather than being proactive in identifying issues for themselves. We spoke to the registered manager about some of the issues we found and they were keen to know where they could seek assistance and information to ensure the service was run to the highest standards.

People and staff spoke highly of the registered manager and deputy manager. A person told us "[The registered manager's name] is OK". One member of staff said, "[The registered manager] is still quite new. [They] are very good, very conscientious" and continued to say "[They] will ask other people's opinions; I really like that about [them]." Another staff member when asked about the management said, "Yes, they've, made a difference. It's a lot better". This member of staff continued to say "Their focus is all about the [people]". A third member of staff said "They [meaning the registered manager and deputy manager] are both approachable. I feel confident to say if I don't agree with something and ask them to explain they do".

Health and social professionals we spoke with all agreed the registered manager was professional and positive. One said, "[They] are good. Good rapport with the person." Another health and social care professional explained "The registered manager was really geared up for making things happen". There were examples of how the registered manager had appropriately been contacting other professionals to meet the needs of the people living in the home. This was important because most of the people had complex needs which required multi-professional input to support them and meet their care requirements.

The registered manager and provider had a clear vision for the home about people moving on and not being a home for life. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The deputy manager told us they were very supported in their role and thought they could adequately deputise for the registered manager in their absence. Whilst in charge they would have a member of care staff stepping up who had in the past been the deputy manager and acting manager of the home. Most of the staff had been on the team for many years and we were told were "very dependable". We spoke to the registered manager who felt supported by the provider.

All accidents and incidents which occurred in the home were recorded and analysed. Some of the older incidents lacked a manager's review but this was because there was a transition between registered managers. For some incidents there were one-to-one discussions with people. The registered manager had identified this was an area they wanted to improve.

The registered manager kept their skills and knowledge up to date by on-going training and reading. Recently, they had attended train the trainer training for medication so they could train staff within their home and the provider's other services. They had chosen to undertake a level 5 Diploma in Leadership and Management for Care to update their knowledge in line with current good practice. We were told it has helped the registered manager become a more reflective practitioner.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. They had notified and worked with the local authority to meet their requirements. We spoke to the registered manager who understood their roles and responsibilities around contacting external agencies. This meant they knew how to keep people safe by informing other agencies who monitored the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with 2005 Mental Capacity Act when people lacked capacity or had fluctuating capacity. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring there was proper and safe management of medicines. Regulation 12 (g)