Mrs P Barnard

Royal Avenue

Inspection report

77-83 Royal Avenue
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Tel: 01502572057

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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

Royal Avenue provides accommodation, care and support for a maximum of 23 people who have a learning disability. There were 23 people using the service when we inspected on 13 October 2016.

There was a registered manager in post who was also the provider of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Our previous inspection of 17 February 2015 identified that improvements were needed with regard to effective quality monitoring systems and monitoring of complaints. We also identified that the assessment of people's capacity to consent to care and treatment was not being undertaken in line with the Mental Capacity Act, and care plans required more detailed information to reflect individual needs and preferences. We found areas of practice that needed to improve, including protecting people's dignity and maintaining professional boundaries.

We undertook a comprehensive inspection on 13 October 2016 to check whether action had been taken to address the breaches previously identified. Improvements had been made in some areas. However, we found continued breaches in relation to consent and governance of the service.

Whilst the service had made reference to people's ability to consent within their care records, there were no formal capacity assessments in place to determine people's level of understanding in accordance with the MCA. Staff understanding of what the MCA meant in practice was limited.

There were improved processes in place to monitor the quality and safety of the service provided and to understand the experiences of people who lived at the service. However, the management team needed to improve how they analysed the information to implement change.

A complaints procedure was in place, however, actions taken in response to feedback was not always recorded, which meant the management team did not have effective oversight and were not therefore able to monitor trends and recurring themes.

Care plans contained detailed information including people's preferences, their preferred routines, life histories, and hobbies and interests. Risk assessments were in place. However, these needed to be more comprehensive in relation to how risks were managed between people living in the service.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements had been made to ensure medicines were administered safely and appropriately. However, further work was needed to ensure procedures were robust and understood by the whole staff team.

Risk assessments were in place which provided staff with guidance on how the risks to people were minimised. However, there was limited information on how to manage any risks between different people who used the service.

Staff knew how to protect people from abuse, and who to report concerns to.

People were cared for by adequate levels of skilled staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not make sure that people's capacity to consent to care and treatment was assessed. There were no formal capacity assessments in place to determine people's level of understanding in accordance with MCA.

Staff were trained in subjects relevant to the people they were caring for.

People were supported to access health care professionals when required.

Is the service caring?

Good

The service was caring.

Staff knew people who used the service well and had good knowledge of their needs, likes and dislikes.

The atmosphere in the service was relaxed and people were listened to.

People's dignity and privacy was respected and maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The management team had implemented systems which enabled people to complain or comment about the service. However, actions taken to resolve concerns were not formally recorded.

Care plans were person centred and included information about people's preferences, their preferred routines, life histories, and hobbies and interests.

People had access to a range of activities and accessed the community often.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems had been implemented, but the management team were not analysing information to give them effective oversight, or using the information as an opportunity to implement change.

People, staff and relatives all felt they could raise concerns or issues to the management team, and felt listened to.

The management team welcomed support from outside agencies to improve the care offered and increase staff knowledge.

Royal Avenue

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 13 October 2016, was unannounced and undertaken by two inspectors.

Before our inspection a Provider Information Return (PIR) was submitted by the registered manager. 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 also spoke with the Local Authority and the Medicines Optimisation Team who had previously visited the service.

During the inspection we spoke with eight people living at the service, the registered manager, two deputy managers, and five care staff. We also observed the interactions between care staff and people. Following the inspection we spoke with three relatives.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt well supported with their medicines. One person said, "They [staff] look after my medications, I could self-medicate if I wanted. Sometimes I choose not to take it, but that's my choice". People were supported to take their medication in their preferred way. One person's care plan said, "Use a spoon and put my medication on top of jam or yoghurt. Make sure that you tell me that my medication is on the spoon and I can see it".

Staff were provided with training in medicines management. One staff member said, "I observed the senior staff three or four times before I could do medication on my own". The service had received support from the local medicines optimisation team, following concerns around stock control, controlled drugs [CD], [medicines that require extra checks and special storage arrangements because of their potential for misuse] and inaccurate recording in Medicine Administration Records [MAR]. Two senior staff had taken on the role of overseeing improvements to medicine administration, and told us they were fully supported by the management team, who were shadowing staff to ensure a consistent approach was taken. They demonstrated a good awareness of safe processes in terms of medicines storage, administration and the purpose of the medicines prescribed for people.

Senior staff had taken on board the advice given from the medicines support team, and acted on this to improve systems, for example, they had made contact with the GP regarding people who refused medicines and requested reviews. Unused stock had been returned to the pharmacy, and was not being re-ordered routinely if sufficient stock was already in place. MAR charts we looked at were correctly completed. Where gaps were found, this was explained on the chart. Where medicines were given on alternate nights, this was made clear on the MAR chart to ensure accurate administration. CD's were kept securely, double signed, with correct stock levels noted.

Improvements were required to ensure the safe management of medicines. The management team recognised that on-going work was required to improve their systems, and ensure that their procedures were robust and understood by the whole staff team. Concerns had been noted by the medicine optimisation team, particularly around people who do not take their medicines before they independently go out for the day, or away for a night. Medicine plans needed to be put in place for these occasions and some progress had been made towards this, for example, contact had been made with the GP for advice as to the time frame in which certain medicines could be taken. This would allow the person to have their medicine prior to going out for the day or at a more convenient time. The management team welcomed on-going support from the medicine optimisation team, as well as closer liaison with the supplying pharmacy.

People told us they felt safe. One person said, "I feel safe in every way. The staff look out for you, they really are very good".

Staff had received training in safeguarding and had the knowledge and confidence to identify safeguarding concerns and knew how to report any suspicions of abuse to the appropriate professionals. One staff member said, "I would report it straight away to management, the CQC, or Customer First if it was about the

management team". Another staff member said, "Safeguarding is about protecting the residents and making sure that they are in a safe environment". The service had received several visits from a member of the safeguarding team last year, who told us they provided guidance and support to staff so they had the knowledge to support people living in the service appropriately. The registered manager had recently contacted the safeguarding team regarding a concern she had for a person living in the service. However, where one person had required hospital treatment following an altercation with another person, there was no evidence that this had been referred to the local authority. We discussed the importance of reporting any concerns with the management team.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks associated with moving and handling, use of bed rails and epilepsy. However, there was limited information on how to manage any risks between different people who used the service, for example, if a person became distressed. Where one person had a support plan to help them when they became angry or upset, there was no risk assessment in place. We saw that incidents had occurred between some people who used the service. It was not clear from the care records what action staff should take to minimise the risk of incidents occurring only the action to take once the incident had occurred. This meant that staff had limited information on how to prevent incidents from happening and how to keep people safe in this situation.

Where one person had fallen, we saw that the risk assessment had been reviewed and updated to include the possible cause of the fall to minimise the likelihood of the incident occurring again. Risk assessments supported people to be as independent as possible and covered the things that a person could do for themselves. One person said, "I go into town on my own, the staff help me get ready and off I go".

People we spoke with told us that they felt that there were enough staff working in the service to provide assistance when they needed it. One person said, "Yes, when I need their help they help me". Another said, "There are plenty of staff about". Staff we spoke with told us that they felt that there were sufficient staff to meet people's needs safely. One staff member said, "We are usually ok staff wise, and we are never left unsupported. If I need the help of a colleague, I can get it". We saw that staff were attentive to people's needs and requests for assistance were responded to promptly.

The registered manager asked a staff member to step in and cover a meeting due to the inspection taking place. This showed us that the service was able to be flexible and had adequate staffing levels to accommodate people's needs when unplanned changes occurred. Staffing levels were calculated weekly, depending on what activities and appointments people had planned.

The service followed safe recruitment practices. Checks had been carried out to make sure people were of good character and suitable to work with vulnerable adults.

There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. The guidance was in pictorial form to enable people living in the service to understand. People had personal emergency evacuation plans which outlined the assistance people required to leave the building in an emergency situation.

Equipment such as electric beds and hoists had been serviced this year. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria. Environmental health were due to visit the service to test the water temperatures.

Requires Improvement

Is the service effective?

Our findings

At our inspection of February 2015, we found that care records did not include written assessments on mental capacity or how staff were able to ensure they acted in the best interests of people who were unable to communicate verbally. This placed people at risk of receiving care and support that they did not consent to. At this inspection we found that whilst the service had made reference to people's ability to consent within their care records, there were no formal capacity assessments in place to determine people's level of understanding in accordance with the MCA.

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 are called the Deprivation of Liberty Safeguards (DoLS).

There was a continued lack of understanding about what the MCA meant for people living at the service. One person's care plan said, "[Person] does not have the capacity to consent to care and treatment, please document advice provided in [persons] best interests". There was no formal assessment of the persons capacity, or what 'care and treatment' they received. There was no reference as to whether others had been consulted in deciding what was in the person's best interests or any evidence of the best interests decision that had been made. Some staff had received training in MCA and DoLS, however, one staff member could not remember what the training was about and one staff member said that they had not had training recently. We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals and where and how they wanted to spend their time.

Care records included documents which had been signed by people to show that they had consented to their care and been involved in their care planning. Applications had been made for DoLS authorisations. However, the local authority had also identified that there was a lack of MCA assessments and best interest decisions in March 2016, and we could not see that this had been addressed appropriately.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Our previous inspection of February 2015, identified that people at nutritional risk had no plan in place to support them to gain weight. At this inspection we saw that there was Malnutrition Universal Screening Tool [MUST] guidance available which assisted staff to recognise if people were at risk of not eating enough. However, this tool was not being used for those people who required this. We were told that staff training was booked to provide further guidance on how to use the tool and it would then be implemented. We did

see that where issues had been identified, such as weight loss, guidance and support was sought from health professionals, including a dietician, and their advice was acted upon.

People were supported to eat sufficient amounts and maintain a balanced diet. However, the service did not effectively monitor the fluid intake of people who had been assessed as requiring this. Fluid charts had not always been totalled to establish the total fluid intake for each day and to monitor that the intake was adequate for their needs. There was no guidance available for staff on the action to take if a person did not reach the recommended amount of fluid. We did however see that this issue had been discussed during staff supervision sessions, and the importance of accurate recording.

People were complimentary about the food they were provided with and we saw that people had a variety of different meals at lunchtime. The atmosphere was relaxed and calm and people were chatting to each other. One person said, "[Registered manager's] cooking is spot on, there is no faulting that. We normally have a menu but it is not set. We choose from about three hot dishes or have what we want". We saw that people were offered a choice of meals, including being shown the two meals on offer to allow them to make a choice based on the appearance of the food.

People were encouraged to eat independently and staff promoted independence where possible. Where people required assistance to eat, this was provided while allowing people to eat at their own pace. One staff member said, "People are involved in making their own packed lunches and getting their own breakfast".

People told us that the staff had the skills to meet their needs. One person said, "The manager and deputies are well trained. In fact, the seniors do a good job too". Another said, "They all know what they are doing".

The provider had systems in place to ensure that staff received training, achieved qualifications in care and were supported to improve their practice. Staff told us that they felt that they were trained and supported to meet the needs of people who used the service, felt confident in their roles and had regular supervision. Training included, autism, moving and handling, safeguarding, managing behaviours which challenge, and first aid. There were also two dementia care coaches [staff with specific knowledge in caring for people living with dementia], who were sharing their learning during sessions with other staff in the service. This helped staff understand how to deliver care which met the needs of people who were living with dementia, such as approaches and communication methods.

One staff member said, "Good opportunities to increase your learning here, very informative". Another said, "I like to know what is expected of me and if I am not confident I will ask. I had a supervision in September and it covered residents care and roles and responsibilities". The deputy managers provided supervision to the staff and worked alongside the staff team daily. This meant that any issues could be addressed promptly. Supervision notes did not always document the progress that a staff member had made towards addressing any areas for improvement. The management team said that they had already identified this and were taking action to make improvements.

The service was up to date with current best practice guidelines in relation to training in health and social care, including the introduction of the Care Certificate which we saw evidence of being completed by two new members of staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work. Each staff member had an induction on commencing employment at the service and shadowed staff to gain knowledge of the role. One staff member confirmed they had an induction and said, "The induction covered roles and responsibilities and I read the policies and procedures and the care plans". Another staff member said, "I am now doing the Care Certificate".

Records showed that people were supported to maintain good health, have access to healthcare services and receive on-going healthcare support. One person told us, "I have seen the doctor recently". Another said, "I have been to the opticians to get some new glasses today".

Good

Is the service caring?

Our findings

At our last inspection of February 2015, we identified that staff would benefit from further guidance and training in relation to promoting people's dignity, and ensuring relationships remained within professional boundaries. At this inspection, we found that staff understood how to respect people's privacy and dignity, and gave us examples of this. We saw one staff member asking a person if they would like help before supporting them to clean their mouth after their meal, and supporting another person to dress in their room, ensuring the door was shut and their privacy maintained.

Staff communicated with people in a caring and respectful manner and spoke about them in a respectful way. They communicated in an effective way by making eye contact with people and listening to what people said. Where people responded well to humour, staff joked with people and there was lots of laughter. The service had a warm, friendly and relaxed atmosphere. Communal areas were clean and furnished with a variety of chairs and pictures that made it feel homely. People spoken with said that the staff were caring and treated them with respect. One person said about the staff, "They are lovely and they help me out if I am feeling down". Another said, "The staff are kind here, it's a good place". A relative commented, "They [staff] interact with residents with kindness and empathy".

The service had purchased privacy screens, so if anyone became ill in a communal area they could use these to ensure privacy and dignity for the person. Staff had received training from the local authority in relation to dignity, and were waiting for on-going support from them to enhance their practice further in this area. There was a 'dignity tree' stencil on the wall in the dining area, which identified key areas that were important to remember when providing support to ensure that a persons dignity and privacy were respected. For example, it said " Allow me time to eat and don't rush me", and, "Value me as an individual".

Care plans included a one page profile. These profiles were detailed and included the most important information about a person. People's views were listened to and taken into account when their care was planned and reviewed. People told us that there was a also a feedback form that they could complete if they were not happy. People told us that they had 'house meetings' where they could give their views and raise any issues. One person said, "We have had a couple of meetings this year and we spoke about going away for a weekend to Butlins. We haven't been yet as it has been very busy with the new kitchen being done". We reviewed the minutes of the resident meetings, and saw that people's views were sought in relation to activities, key workers, respect and dignity of others, and planned educational topics.

People had keyworkers, [Staff who are assigned to work with specific people to provide continuity]. One person said, "I usually spend time with my keyworker every week. My keyworker helps me with a few things". People and their representatives were involved in making decisions about their care. For example, we saw a letter to one persons representative regarding the possibility of one person moving bedrooms to share with someone they had a good relationship with. One person said, "I am involved in decisions about my care and when I first moved in, I sat with the deputy manager and read right through my care plan to make sure that I understood everything and signed it".

People's independence was respected and promoted and people were given choices. During our inspection we saw staff encouraging people's independence, including taking their plate to the kitchen after a meal. One person said, "I have my own personal room and my privacy. I have my independence here". Another person showed us their bedroom which was decorated in pink and purple and told us that they had chosen the colours.

There was an advocacy poster on display and people were supported to access an advocate where this was required. The deputy manager told us that three people regularly saw an advocate [records confirmed this] and gave an example of how the advocate is working with one person to support them to make a decision about some potential dental treatment that is required.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection of February 2015, the service could not demonstrate how people's experiences, concerns and complaints were used to improve the quality of care, or how they learnt from these. At this inspection, the registered manager told us that comment cards and six monthly satisfaction surveys had been implemented to ensure that people were able to raise issues and voice any concerns. We saw that the complaints procedure was visible at the front entrance for people and visitors to see which was in response to a relatives request. People told us that they knew how to make a complaint and resident surveys confirmed this. One person said, "I don't feel listened to all of the time, there are certain members of staff who don't listen to me". However, they went on to say, "If I'm not happy, I put a complaint in and they [management] sort it out". Another person said, "They listen to me, it all gets sorted out by the manager as they are in charge".

The management team gave us examples where they had used general feedback to make changes, for example, putting computers and televisions in people's bedrooms. Other issues which resulted in a complaint were related to interactions between people and staff and these had been dealt with by the management team. However, these complaints were still not formally documented with how the management team responded and the actions which had been taken. This would enable the service to have effective oversight and identify any recurring themes which they could then use to make changes across the service to benefit others.

At our last inspection we found that care plans lacked detail and that people had not contributed to creating their care plan. At this inspection, the registered manager told us that the staff team had received care plan training from the local authority and they had learnt a lot from this. We found that care plans were now written in a person centred way and included information about people's preferences about how they wanted to be cared for, their preferred routines, life histories, hobbies and interests. This showed that people had been involved in their care planning. Care plans included information about people's specific needs and how these were to be met. Some care plans had been reviewed and where people's needs had changed, plans were updated to reflect how their changing needs were to be met. Daily care records included information about people, such as the care they had been provided with and their wellbeing.

Care plans had evidence of goals, for example, to encourage independence skills and to explore and engage with new activities. Some care plans were newly created. We saw that some care plans had evidence of review and people had been involved in this process, however, we could not see that all of the care plans we looked at had been reviewed and progression towards goals discussed. The document outlining the roles and responsibilities of the keyworker said that care plans should be reviewed three monthly. The deputy manager told us that more responsibility was being given to the keyworkers and that that this would be addressed promptly.

People told us that they felt that they were cared for and their needs were met. One person said, "I am very happy living here". Another person commented, "The best thing is that I have my own bedroom and we have parties here". A staff member said, "It's a very jolly atmosphere here, we have a responsibility to ensure

people are well cared for, and it's a privilege to be part of it".

Staff were attentive to people's needs, and requests for assistance were addressed. When one person became upset, we saw that a staff member provided assistance and reassurance. This meant that staff responded to people's needs. Another person became quite upset due to an incident that occurred. The registered manager spoke calmly to the person, provided reassurance and suggested that the person moved to a different area of the house. This approach defused the situation and the person appeared happier.

There was a plan of weekly activities which included one to one time. One of the rooms in the service was being refurbished into an education/beauty room. There was a dedicated activity area with crafts, music and games and a table tennis table. One person said, "I am a big snooker, darts and pool fan and the male staff play these activities with me". During the day, people were singing and dancing and taking part in craft activities. People had been making things for Halloween and the activity room was decorated in a Halloween theme. People were excitedly talking about what they were going to dress up as for a Halloween party that was taking place. We saw a person playing with feathers in the activity room and another completing a jigsaw. There was a well kept garden with a pond and vegetable patches, and a shed which was used as a gym with weights and exercise machines.

People accessed the community regularly and one person went for a walk down to the beach on the day of inspection. Some people were independent and attended college. One person said, "I go into town and there is always enough to do". Another person said, "I go to restaurants and I have hobbies. I go round the museum and get books out of the library". A staff member told us, "There are definitely enough activities in house and there are also activities that people attend out of the service such as Tuesday club and Friday club. We also have planned activities in the evening".

People told us that they could have visitors when they wanted them. One person said, "My dad comes and he also takes me to see mum". A relative said, "I can come and go as I please, and if I can't get there [registered manager] tells me how my [relative] is".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of February 2015, we found that the registered manager did not have systems in place to monitor the quality of the service provided, and use this to drive improvement. At this inspection we found that systems had been improved, for example, there were now medicines audits and competency assessments, observation checks on staff, infection control audits and cleaning schedules. Accident and incidents had been recorded and were kept in people's care files. However, these were recorded in a variety of different formats, for example, a body map, accident form, incident form and another recording form. This made it difficult to have effective oversight of all incidents which had occurred, as they were not being held centrally by the management team which would enable them to have an opportunity to identify recurring themes or trends. It was not always clear how incidents had been analysed or any lessons learned from them. This was also the case with documentation relating to complaints, and the lack of formal recording. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reason for this should also be recorded.

Providers are required to send the CQC statutory notifications to inform of certain incidents, events and changes that happen. Whilst the service had sent in some statutory notifications to the CQC, we had not received all notifications of injuries sustained by people at the service from falls or incidents between people living at the service. We advised the management team to familiarise themselves with the range of incidents that require a notification to be sent to the CQC.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had some concerns regarding professional boundaries between people living in the service and the registered manager. People we spoke with referred to the registered manager as 'Mum'. People generally spoke fondly of the registered manager. One person said, "[Registered manager] has been fantastic to me. She is more like a mum to me". Another said, " [Registered manager] is a dime. They count all the residents as their own in a nice way". We discussed the importance of having professional boundaries in place with the management team, who told us that they had learnt at the previous inspection that they needed to take steps to ensure that they do not cross professional boundaries and had sought training in respect of this. They had asked people not to refer to the registered manager as 'Mum' and to remember that staff are not family members. However, when we spoke with people, they told us this was their choice and did not feel this was inappropriate given how caring they felt the staff were generally and the relationships they had built up over a long period of time. We observed strong relationships between staff and people generally, but these interactions were seen to be appropriate and supportive.

People felt listened to. One person said, "I tell [registered manager] face to face if I am not happy or I give them a call". We saw that satisfaction surveys had been issued to people and relatives for their feedback. This feedback was mainly positive, one relative said, "The care my [relative] receives is amazing, and they [staff] always call me if there are any issues". Where issues were raised, such as a request by one person for staff to stop using bleach in their room, and another asking staff not to turn off their gaming device, this had

been acted on and communicated to the staff team.

Staff meeting minutes discussed relevant topics including how they promote people's independence and skills, improvements in medicines management, and learning through reflection by asking staff, "What would you want if you lived in a residential home?". This feedback was discussed with staff and then asked the question, "Are we providing this to people?". This was effective in helping staff think about how they deliver care to people and how they can further improve.

One deputy manager said, "[Registered manager] is proactive about change and anything that is suggested is done straight away. Repairs are always done promptly. I feel well supported and having another deputy has made a big difference as they have extensive knowledge and background. We have good working relationships with the dignity and infection control team and are getting the support that we need". The deputy manager told us of improvements that the service was focussing on and explained that they had worked hard to ensure that the staff team knew what was expected of them in their roles and had made some changes to the staff at the service as a result of some safeguarding concerns. The management team were trying to be more professional within their role due to becoming too familiar and informal with the staff team which had caused some difficulties when managing performance. The management team told us how they had worked with other agencies, such as the local authority, to learn and improve. This support was on-going and was welcomed by the management team who saw this as an opportunity to avoid becoming isolated due to being a small care provider.

Staff told us that they felt that the service was well led. One staff member said, "We are looking at possibly changing the shift patterns to make the handover more efficient following feedback from the staff team". Another said, "There are many opportunities to speak up and staff morale is good. We have staff meetings and if we are not happy, we write a concern form and it is dealt with and I get feedback on how it was dealt with".

The management team kept up to date with best practice through attending events, for example, infection control link meetings, registered manager networks and dignity forums. The service was also part of the National Care Homes Association. This also ensured that the service did not become isolated and they could share best practice with other services to ensure continuous improvement.

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 11 HSCA RA Regulations 2014 Need for consent There were no formal capacity assessments in place to determine people's level of capacity in accordance with MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective as they were not being analysed to enable effective oversight or used to implement change.