Randale Care Limited

Red House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

The inspection took place on 28 and 29 January 2016 and was unannounced.

Red House Residential Home provides accommodation and personal care for up to 15 older people, some of whom may be living with dementia. At the time of our inspection there were 12 people living in the care home because double rooms were being used for single occupancy. The provider also operates a domiciliary care service from the same location, offering support and personal care to people living in their own homes.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider has a nominated individual who takes responsibility for representing them as registered persons. The nominated individual maintained a regular presence within the service and was actively engaged with service delivery, particularly in relation to support people received in their own homes. The registered manager and nominated individual are referred to within the report as the management team.

People experienced a service that was safe. They received assistance from staff with their support needs in a timely manner. Staff and the management team understood their obligations to report any concerns someone may be at risk of abuse or harm. Staff also understood the risks to which people were exposed and how they needed to support them safely.

People's medicines were stored and administered safely.

The service people received was not wholly effective. Staff had not been properly trained to understand how to support people who could not make decisions for themselves, and their responsibilities under the Mental Capacity Act 2005. People's capacity to make specific informed decisions and to understand risks, was not properly assessed and recorded. We have told the provider they need to make improvements in this area.

Staff had a clear understanding of their roles and people's needs and had access to support from the management team when they needed it. They ensured advice was taken from health professionals if people became unwell and tailored the care they delivered in response to changes in people's health.

People had enough to eat and drink and were offered choices about their meals and drinks. Staff presented food in a way that was appetising and offered people condiments to go with it.

People received support from staff who were kind and compassionate. They took action to intervene promptly when people became anxious. Interactions between people using the service and staff were warm, respectful and polite.

Staff understood people's preferences for the way they wished their care to be delivered and respected these. They communicated well with one another about people's support and any changes that needed to be followed up. This helped to ensure people were supported in the right way.

People were confident that, if they needed to raise a complaint or concern, the management team would take this seriously and respond to them.

Systems for assessing and monitoring the quality and safety of the service were not sufficiently effective. This compromised the ability of the management team to identify improvements that were needed. There were shortfalls, particularly in relation to record keeping, assessments of risks and supervision, which had not been addressed promptly. We have told the provider they need to make improvements in this area.

Staff were highly motivated and enthusiastic about their work. They understood the standard of care that they were expected to deliver. The management team had developed a culture within which staff and people using the service felt free to seek support if it was needed, to ask for advice and to raise suggestions.

You can see the action we have asked 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?

Good

The service was safe.

Recruitment processes were robust and staff understood the importance of protecting people from abuse. There were enough staff to attend to people's care needs safely.

Medicines were managed in a way that promoted people's safety.

Equipment was tested regularly to ensure it remained safe for people and staff to use and emergency systems for detecting and extinguishing fires were properly serviced.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training and support to learn from experienced colleagues. However, they were not well prepared and trained to understand how to support people who may lack capacity to make informed decisions about their care.

People had enough to eat and drink.

Where there were concerns about people's health, relevant advice was sought promptly.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

People were treated with respect for their dignity, independence and preferences.

Is the service responsive?

Good

The service was responsive.

Staff were flexible in responding to people's changing needs. They had a sound understanding of people's preferences and what was important to them.

People were confident that any concerns or complaints they raised would be properly addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems and processes for monitoring the quality and safety of the service were not fully effective in identifying where improvements were needed.

Records were not updated promptly when it was needed.

The management team promoted an open culture, focused on the needs of each individual, and where people and staff were empowered to express their views.

Red House Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 28 and 29 January 2016 and was unannounced. It was completed by one inspector.

Before we visited the service we reviewed the information we held about it. The information included notifications about events taking place within the care home and domiciliary care agency which the provider is required to tell us about by law.

At the inspection we spoke with four people living in the care home and three of their relatives. We also talked with a member of the district nursing team. We spoke with four members of staff and the registered manager. We also spoke with the member of the management team who was the provider's nominated individual. On 1 February 2016, we spoke with four people using the domiciliary care service that the provider operates from an office within Red House Residential Home.

We observed how staff were supporting people. We reviewed care plans for four people living in the care home and looked at their medication records. We also reviewed assessments and plans of care for two people receiving support in their own homes.

We reviewed training records for the staff team in both the care home and the agency, and recruitment records for one staff member recently appointed. We also looked at other records associated with the quality and safety of the service.

Good

Is the service safe?

Our findings

People spoken with told us that they felt safe using the service. For example, one person living in the care home told us, "Oh yes, I'm 100% safe." Another person receiving support in their own home said, "Yes, I do [feel safe]. I have no concerns." People were confident that the provider would not allow staff to work with them if they did not maintain acceptable behaviour. One person told us, "I don't think [nominated individual] would have staff if they messed about."

Staff were clear about their obligations to report any concerns that people may be at risk of abuse or harm. They were confident that the management team would deal with any such suspicions. We found there was guidance for staff about how they could report suspected abuse to the safeguarding team directly. The provider's training schedule confirmed that all staff had received training in this area to contribute to protecting people from abuse. One staff member's training was due for renewal but everyone else had received training within the last year.

Staff within the care home confirmed that they had training in fire safety and this was supported by records. These records also showed that staff had taken part in fire drills. The provider's records showed that monthly tests 'in house' of emergency lighting to ensure that this would work properly were slightly overdue. However, these lights and the fire detection system were serviced by an external contractor to ensure they would work properly in an emergency. The servicing was in progress when we visited the care home. We noted that equipment, such as that for moving people safely, was checked to ensure it was safe to use.

People's plans of care contained assessments of risk to which they were exposed with guidance about how these were to be minimised. Some information was out of date but staff were able to tell us about changes, the current risks to which people were exposed and the support they needed to offer to minimise these.

We saw that staff encouraged people to use walking frames or walking sticks where this was necessary to minimise the risk of falls. They ensured that people had these within easy reach when they were seated in arm chairs. We saw that these aids were offered to people promptly after they had finished eating their meals and wished to leave the table, so that they could move safely. Staff intervened quickly to ensure that one person did not slip on some food that had been dropped on the floor.

Risks associated with poor nutrition or hydration were taken into account, with guidance about fortifying diets for people identified as at risk of weight loss. One person was at some risk of choking. Their care plan identified that staff may need to assist and cut up their food into small pieces. We saw that staff offered this support. Staff were aware who was at risk of developing pressure ulcers and we saw that equipment was in place to reduce this risk where it was appropriate.

Staff told us that people using the domiciliary care service had assessments of risk on their files in their own homes. We saw that reference to risks for these individuals and for staff working with them were contained within the electronic records system used for that service.

People living in the care home told us that they did not have to wait long for staff to respond to requests for assistance. One commented, "They come almost instantly. Sometimes I have to wait a bit if they're dealing with someone else, but that's fine." Three visitors told us that they had never had concerns about call bells ringing for a long while without being answered. We noted that call bells were responded to promptly throughout our inspection. Visitors also told us that they did not have to wait long for staff to let them in when they rang the doorbell. One visitor commented that staff always had time to talk to people. People receiving care in their own homes told us that staff arrived for their calls on time, unless there was an emergency. They told us that staff stayed for the expected amount of time and always had the opportunity to chat with them

Staff in the care home told us that there were two care staff on duty on each shift. Overnight there was one waking night staff and one person available if required who slept in at the care home. This was confirmed by duty rosters supplied to us. We discussed with a member of the management team that some people living in the care home had failing health which would place additional demands upon staff over time. They assured us that this would be reviewed. A visiting health professional told us that they knew staffing arrangements had been altered in the past in response to changing needs.

During weekdays, at least one of the management team was available and we saw that they assisted staff with serving meals during our inspection. However, they were not present at weekends. Staff said that it was normal practice for the management team to help out during the week if necessary. They said that it was very busy at weekends but they did not feel they were short staffed, or that staffing levels were unsafe. They told us that one of the management team was on call and they were always able to make contact with them in an emergency.

We concluded that there were enough staff deployed to meet people's needs and that the management team was flexible about staffing levels when people's conditions changed.

We reviewed the recruitment checks that were completed for one member of staff newly appointed. These showed that the staff member's employment history had been checked and references were taken up. They had attended an interview and interview notes were completed so their suitability for the work could be evaluated. We noted that, before they were confirmed in post, they were properly checked to ensure that they were not barred from working in care services.

We concluded that recruitment practices contributed to promoting people's safety.

People living in the care home were satisfied that staff provided them with their medicines at the right time. One person also commented that if they needed anything for pain relief this would be fetched promptly when they asked. A visitor confirmed this was the case. A person receiving care in their own home also told us how staff made sure their medication was available to them so that they could take it at the right time.

In the care home, we saw that the medicines trolley was secured to the wall safely when it was not in use. We noted that, when staff were administering medicines, the trolley was locked when it was unattended and no medicines were left accessible. Staff made sure there were drinks available for people to take their tablets with. We saw that the staff member responsible checked the medication administration record (MAR) chart, 'dotted' medicines on the relevant section of the chart as they were prepared, and signed them after they were sure the person had taken them.

The management team informed us that staff completed workbooks for medicines awareness and their practice was observed to ensure staff were able to administer medicines competently. We were aware from

one notification that appropriate action was taken to reassess competency if there were concerns about practice.

We checked the records relating to one controlled drug supplied in a 'patch' for pain relief. We found that this was appropriately stored and recorded. The balance of the medicine remaining in stock corresponded to what had been supplied and administered.

We concluded that the arrangements for managing medicines contributed to promoting people's safety.

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. 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).

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.

We found that training records did not include any reference to training in the MCA or DoLS. Staff that we asked about this said they did not have specific training in these areas but one confirmed they had covered it as part of a qualification in care that they were completing.

We found that there were no assessments of people's capacity to make specific and informed decisions about their care contained within care records. For example, one person's care plan showed that they had difficulties swallowing and may need soft food or food cut into small pieces. Staff told us how the person had asked for roast potatoes, which staff recognised might not be appropriate. The person's capacity to make an informed decision about taking the risks associated with meal or drink choices was not assessed and recorded.

Staff told us how they responded flexibly to people who declined personal care and that they would return later and offer the required support. However, we noted that one person was described at hand-over as 'uncooperative' with personal care when staff considered it was essential to address continence issues. There was no underpinning assessment of the person's capacity to give informed consent to receiving care. There was a lack of documentation about what represented the person's best interests and how staff should respond to this.

For one person we found that their care records identified that they had a person with lasting power of attorney (LPA) over their finances. The records did not contain a copy of information confirming the arrangement. Records also stated that the person with the LPA, "…does finances and everything else." This presented a risk of misunderstanding that the person with LPA over finances could also make decisions to do with care and welfare of the person living in the care home, when they had no legal authority to do so.

We noted that care plans contained assessments of risk for people leaving the care home. In some cases these indicated that people were not free to leave the home unaccompanied and that a trained carer, volunteer or relative would need to remain with them all the time. There was also information about contacting the police so that people who succeeded in leaving unaccompanied would be returned to the service. There was no assessment of the capacity of each person to understand relevant risks, consideration

of what represented their best interests and the least restrictive option to ensure their safety. No applications had been made for authorisations under DoLS to consider whether people were being deprived of their liberty.

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

A visiting professional told us how they felt that the management team had an understanding of the MCA legislation and the need for consent. They told us that the care team were less aware but went on to explain that staff were aware people's capacity might vary. They gave an example of where staff had advised them they may not be able to assist the person with dressings on a particular day and might need to return on another occasion.

We found that staff training records did not show that training the provider considered mandatory was always renewed promptly when it was required. For example, although first aid training had been completed by all staff, it was overdue for renewal for six of the 15 staff currently working in the care home. Three had last completed it in September 2014 and three in November 2014. The manager confirmed that they intended to arrange for this to be renewed. This training was up to date for staff who worked with people in their own homes.

People living in the care home and those receiving support in their own homes told us that they felt staff were competent to meet their needs. For example, one person using the domiciliary care service said, "Staff are competent. They seem well trained. I haven't had to explain what needs doing and how to do it."

Staff told us that they had access to training including training for using equipment. One staff member explained to us how they had experienced being hoisted and hoisting their colleagues so that they understood how this would feel for people who needed to use the equipment.

Staff confirmed that they had opportunities to 'shadow' more experienced colleagues while they developed confidence about meeting people's needs. One new member of staff said that this was working well and they felt able to ask their colleagues if they were unsure about anything. One experienced staff member told us how they had almost completed a qualification in care.

We spoke with staff about the support they received from the management team. Records showed that formal supervision did not take place regularly but staff told us that they felt well supported and could go to the management team for advice. We found that formal supervision had been provided when concerns about staff performance needed to be addressed.

People told us that they enjoyed the food that was prepared in the care home. One person told us, "It's really lovely." They said they had enough to eat and drink. Another person told us how staff regularly replaced the jug of drink they had in their room.

Staff recognised that they may need to offer encouragement if anyone was not eating well but told us that no one needed assistance to eat or drink. We noted that people's weights were monitored regularly so that action could be taken if there was any unintended weight loss.

We observed that drinks were taken around regularly during the course of the day and people were asked what they would like. Biscuits were also offered to people with their mid-morning drinks. We saw that people had a choice of main meal which was well presented and smelled appetising. People were offered

condiments to go with their meal if they wished. During the afternoon we noted that a staff member checked with people what they wished to have for their tea that day and what they would like for lunch on the following day.

People told us that staff would arrange for them to see the doctor if they were unwell. One person told us how the chiropodist and optician came to see them regularly. We also found from records that people were supported with hospital appointments and advice was sought from an occupational therapist when required.

We observed that the district nurse visited people who needed their support to maintain their health, including their skin integrity. The nurse told us that staff took prompt action to seek advice about people's health when this was needed. They went on to tell us that staff acted on the advice they were given about people's care and treatment to promote their health.

Good

Is the service caring?

Our findings

We noted one isolated incident that could have compromised people's privacy. We saw that staff discussed who the district nurse had come to see and engaged with the nurse in the hall way. This was outside the dining room and lounge but we noted that one staff member did not lower their voice, risking that the conversation may have been overheard.

People who used the service told us they were satisfied with the care they received and the approach of staff. For example, one person receiving support in their own home said, "They are always polite and respectful. If I need something extra they will do it for me. I'm really happy that I found them." Another person commented, "I like them [staff] very much. I have never been so cared for as by them….I've never met care like it before." A relative of someone living in the care home told us, "It is like a little hotel, not all medical. They treat you like a human being." The person they were visiting agreed that this was the case.

We observed that interactions between staff and people living in the care home were polite and respectful. We saw that, even where people had chosen to keep their room doors open, staff knocked and announced themselves before entering. We observed that when one staff member had their hands full with a meal tray they were not able to physically knock on the person's door. However, they called out, "Knock, knock. Can I come in?" They apologised for not being able to knock properly before they entered the room so respecting the person's privacy and dignity.

We noted that staff asked one person whether they wished to receive a visitor. The person told us that they were confident if they did not wish to see anyone, that staff would respect their rights. A visitor commented to us how they felt their relative's rights to privacy and independence were respected. They told us how the person was encouraged to do as much as they could for themselves. One person receiving care in their own home also told us that staff encouraged them to be independent in some areas but offered help when they needed it.

We saw that a staff member positioned themselves so that they could make eye contact with people sitting in their chairs while they were checking people's preferences for meals. Another staff member took action promptly to respond to one person who needed assistance and had become anxious. They offered gentle reassurance and encouragement, touching the person's hand and talking to them calmly. We noted that another person, needing staff to be present while they walked using their frame, was supported by staff at their own pace. They were engaged in conversation and chatting while this happened.

We concluded that staff had developed warm and kind relationships with people they supported.

People who were receiving support in their own homes told us that they were involved in developing their plans of care. One person said, "I was involved in the care plan and assessment, all of it." Another person living in the care home told us that they did not know about their care plan but were happy that staff supported them in the way they preferred. They thought their relative may have been consulted and were happy for this to have happened. Their relative confirmed to us that they had been involved in talking about

the person's needs, preferences and wishes, so that an appropriate plan of care could be developed. We noted that some people had signed sections of their care plans to show they had been involved in developing them.

We concluded that people, or their representatives if they wished, were actively involved in expressing their views about how they wanted their care to be delivered.

Good

Is the service responsive?

Our findings

We noted that one person was prescribed a powerful controlled drug for pain to be given every four hours if required. We found that their notes showed they had been very restless and complaining of severe back pain during the night. We found that the last dose of the controlled drug was recorded as given at 9pm. This meant that they could have had a further dose during the night to ease their pain. Staff had given the person two paracetamol but the person had difficulty going back to sleep. We raised with the nominated individual that paracetamol was unlikely to be effective in the circumstances. They undertook to review arrangements, although the person themselves was not concerned about the staff response.

One person living in the care home told us that staff knew how they liked things done. Another person receiving care in their own home said, "They accept that I like some things done certain ways. They know everyone is different with different preferences."

A staff member providing support to people in their own homes said that the management team were very responsive to any concerns that people's needs may be changing. They said, "They [management team] always respond to messages. If someone needs a little extra care we report and they get a review going."

We saw that, at hand-over between shifts in the care home, staff shared detailed information about people's needs. For example, one person was reported as having been unwell and with poor balance so staff knew that they would need additional support. They were aware that the person was being treated for a condition which may have contributed to their poor balance. We saw that staff offered additional assistance when the person needed support to move.

We concluded from the questions staff asked at hand-over about people's welfare, that they were aware of people's preferences and were alert to any changes in the support they may need. For example, we noted that staff commented how one person's usual routine was to have a blanket over them at night but they had wanted two. Staff discussed that another person liked to wear makeup but was not managing to apply it very well, so perhaps staff could see if they wanted staff to assist them. We also noted that staff discussed one person's temporary disorientation and anxiety on waking. They recognised this may have been due to their history or to a dream they had been having and agreed they would monitor this to see if action was needed.

People living in the care home expressed varying views about how their hobbies and interests were supported and met. The nominated individual told us that one of the provider's directors normally facilitated an activity group on Wednesdays. We noted that one person expressed to us their wish for there to be more happening in the home. However, they said they had enjoyed painting and decorating picture frames the day before we started our inspection and told us that they were happy watching the television. Another person said, "I don't like to join in. They don't force you." One person told us that they had suggested it would be nice to have bingo and that this was going to be arranged for the following week. During the afternoon of the second day of our inspection we saw that one staff member engaged a person in a game of dominoes, which they were enjoying.

We noted from discussions between staff and the registered manager, that one person newly admitted to the home had expressed their wish to have two newspapers delivered. They had already contacted a local newsagent to see if they would deliver.

A member of the district nursing team told us how staff had responded promptly to changes in someone's skin condition. They felt that the service had responded well to the individual's changed needs. They said that staff had enabled the person to recover more rapidly than they had anticipated.

We concluded that the support staff delivered was focused on, and responsive to, individual needs and took into account their preferences.

We noted that the process for making complaints about the care home service was clearly displayed on a noticeboard in the hallway. This was at a suitable height for people using wheelchairs and just above the visitors' book so that they could see it easily. Information contained details of the process and also of the Care Quality Commission if people were concerned about the standard of care. No concerns had been raised with us. People receiving support in their own homes told us that their files contained a telephone number they could use to contact a member of the management team and raise any concerns they might have. One person confirmed to us that they had information about making a complaint but had not needed to use it.

One visitor to the home was not sure how they would raise a complaint. However, they told us after reflection, "I suppose I do [know] but I've never had anything to complain about." One person living in the home said, "I'm not sure about complaints but I would jolly well find out." Although some people and visitors were not always clear about the process for raising a complaint, because they said they had not needed to, they all expressed their confidence in the management team to respond.

Requires Improvement

Is the service well-led?

Our findings

The current provider registered with the Care Quality Commission in March 2015 after the care home had been operating under a different provider for many years. The delivery of personal care to people in their own homes was a newer and developing activity. We found that systems for governance were less effective within the longer standing care home service than they were in the domiciliary care service. Systems had not robustly identified shortfalls and some information had not been updated since well before the current provider took over.

Staff had no concerns about a lack of support from the management team. However, they were not receiving supervision in line with the provider's expectations. Guidance said that staff should receive supervision every six to eight weeks. We found significant gaps. For example, the schedule showed that some staff had not received any supervision since February 2015. Supervision is needed so that work, performance, development or training needs can be discussed and addressed.

Training and development was not properly reflected in the records of training sent to us by the registered manager. The training list did not reflect best practice in terms of changes to induction to show that the provisions of the new Care Certificate had been taken into account. Some basic training, which the management team considered required regular updates, had expired. We were aware from one staff member that they were completing a qualification in care but this did not show on the training matrix. Combined with a lack of supervision, this meant that it was difficult for the provider to demonstrate how they were monitoring and developing the staff team and the quality and safety of the service they delivered to people.

The management team told us that they had recognised and discussed the need to update care plans for people living in the home, just before our inspection. They said that they intended designated staff to be trained to help, with dedicated hours to complete the work. However, this was very belated in terms of ensuring that people's care plans and assessments of risk were properly maintained.

We found that care records for people living in the home, marked as needing monthly reviews were not being updated. For example, we found that one person's dependency assessment contained no evidence of review since March 2014, despite staff reporting significant changes in the support they offered to the person. Their moving and handling assessment, also supposed to be updated monthly, contained no indication of review since June 2015. Monitoring systems had not identified that there was a direct contradiction within their records about whether it was safe for the person to administer their own medicines. This was rectified when we pointed it out. However, we concluded there had not been a regular or robust audit to ensure people's records were properly maintained, clear or consistent.

We found that risk assessments for safe working practices throughout the home were shown as needing to be signed by staff after they had been read. However, there had been no signatures entered since April 2013, since which time new staff had been appointed and the current provider had taken over. Records did not therefore show an organised approach to ensuring new staff had been made aware of the information and

underpinning guidance about their safety at work.

Risk assessments for environmental hazards contained no evidence of review since August 2012 to see whether they remained appropriate and adequately controlled risk in line with the current provider's expectations.

The management team showed us an emergency file for staff to use in the event of fire. They had not noted that the list of people living in the home was out of date. This was corrected during our inspection. However, it had presented a risk that the person missing from the list may have been overlooked in an emergency evacuation during a fire. The nominated individual assured us that staff knew what they should do if there was a fire when there were only two of them on duty, but we found that some staff were unclear.

The nominated individual confirmed that the fire service had inspected the service during June 2015. There was no correspondence regarding this on file. They told us that the report had been supplied by e-mail and they had not printed it off. They were unable to locate the relevant e-mail to show whether the report identified any action was needed to improve.

The management team told us that they completed regular 'walk round' checks within the home but acknowledged these were not recorded. As such, there was no clear evidence of what was reviewed, when, or of any action plan to address shortfalls, including those we identified. The last survey for the views of people using the care home, or their representatives, was completed by the previous provider in 2014. The nominated individual told us that the provider intended that a survey within the care home service would be completed in the near future. However, this meant that relevant stakeholders had not been asked for their views about what could improve, for a long while.

We concluded that the provider's systems for assessing, monitoring and improving the quality and safety of the service, including the maintenance of records, were not wholly effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the care plans and assessments for those people receiving care in their own homes were in better order and updated promptly when their needs changed. The nominated individual was reviewing one person's needs after a period in hospital. We concluded that records associated with care and management of risks for people in their own homes were fit for purpose.

We noted that people receiving care in their own homes had been asked for their views in October 2015 to see whether improvements should be made. Their comments were positive about the quality of the service they received.

The management team knew what events they needed to notify to the Care Quality Commission, as required by law.

One person receiving support in their own home told us, "They [staff] are very enthusiastic and I think they love their work." A person living in the care home told us, "I think it's admirably run." They went on to say, "There are no barriers to speaking to the manager if I asked."

Staff spoken with confirmed how much they enjoyed working in the service. They said they valued the accessibility and availability of the management team and were able to seek advice or express their views if they needed to. They had a clear understanding of their roles and the standards of care the management team expected them to deliver. We concluded from our observations and discussions that staff that morale

within the service was good and that they had opportunities to express their views.

We noted that people using the care home service expressed a high regard for the registered manager and nominated individual and had confidence in the way the service was running. Those using the domiciliary care service identified the nominated individual as their main point of contact and again, expressed their confidence in leadership of the service. People and staff were clear that the management team were accessible to them if they needed to discuss anything about the service.

From our observations of interactions between the management team, staff and people living in the home we concluded that there was an open culture where people could express their views. The management team understood the specific needs of individuals using the service and had built up a relationship with them and their family members.

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 People's consent to care and treatment was not properly assessed and recorded. The service did not show that people's capacity and best interests were properly considered and their rights protected. Regulation 11(1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service, including mitigating risks and having regard to the accuracy of records, were not operating effectively. Regulation 17(1) and 17 (2)(a),(b), (c), (e) and (f)