

Precious Homes Limited

Albany House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This inspection took place on 10 February 2016 and was unannounced. At our previous inspection of the service on 15 April 2014 we found that the provider was meeting all of the regulations we checked.

Albany House provides accommodation and care for up to six adults with learning disabilities, who also have Autism Spectrum Disorder. At the time of our inspection there were six people using the service, four women and two men.

There are six single occupancy bedrooms, five of which have an en suite bathroom. There is also a separate shower available. There is a communal kitchen, living room and activity room.

There was not a registered manager in post at the time of our inspection. The acting manager had been employed at the service since July 2015 and had submitted his application to register with the Care Quality Commission. 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.

There were enough staff working on each shift to support people, however the staff team was relatively new and there were staff vacancies that were impacting on the operation of the service. Staff recruitment checks were completed as required but these were not always sufficiently robust to ensure that staff were suitable to work with people using the service.

Risks to people's safety were assessed and management plans were in place that helped reduce the risks whilst balancing people's rights to make their own decisions and medicines were managed safely.

Staff did not received adequate training to ensure that they had the skills and knowledge to meet people's individual needs. Staff received support through supervision and there was an annual appraisal system in place.

People's health and nutritional needs were met and people were supported to make choices about what they wanted to do and what they ate. Staff understood their responsibilities in relation to the Mental Capacity Act and ensured people's consent was sought for any decisions made about their care and support but best interests assessments were not always recorded.

People told us staff treated them well and we observed positive interactions between staff and people using the service.

People's needs were assessed and detailed care plans written so that staff knew how to support people. However, these documents were not organised in a way that made them easy to read and understand.

We found that people were supported to take part in a range of activities that met their interests and saw that people were supported to maintain relationships with people who were important to them.

There were gaps in the leadership team that were affecting how the service was run. However, audits were completed to check how the service was operating and we saw that there were plans in place to make improvements.

We have made one recommendations in relation to care planning.

We found breaches of regulations in related to staff training and record keeping in relation to managing behaviour that challenged the service. You can see what action we have told the provider to take at the back of the full version of this 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?

Not all aspects of the service were safe. Staff vacancies were affecting the operation of the service and recruitment checks were not sufficiently robust at times.

Risks to individuals were assessed and there were plans in place to manage these

Medicines were managed safely.

Requires Improvement ●

Is the service effective?

Not all aspects of the service were effective. Not all staff had received sufficient training to ensure they had the skills and knowledge to meet people's individual needs.

Staff understood their responsibilities under the Mental Capacity Act 2005 and asked for people's consent before carrying out any tasks. However, best interests assessments were not always recorded.

People's health and nutritional needs were met.

Requires Improvement ●

Is the service caring?

The service was caring. People told us that staff treated them well and we observed positive interactions between staff and people using the service.

People were offered choices and steps were taken to ensure that people could communicate with staff and express their views.

People were supported to maintain and develop independent living skills.

Good ●

Is the service responsive?

Not all aspects of the service were responsive to people's needs. People's needs were assessed and care plans developed so that staff knew how to meet these. However, the documents were not always organised in a way that made them easy to read and understand.

Requires Improvement ●

People were supported to take part in a range of social and leisure activities of their choosing.

Complaints were responded to promptly and steps taken to address and resolve any issues raised.

Is the service well-led?

Some aspects of the service were not well led. The manager of the service was not yet registered with CQC and there were staff vacancies for senior staff.

Audits were completed at regular intervals and action plans were developed to address any shortfalls, however, it was too early to tell if these had been effective.

The provider had clear values that were discussed with staff and improvement plans were in place and the manager had started to implement these.

Requires Improvement 

Albany House

Detailed findings

Background to this inspection

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

This inspection took place on 10 February 2016 and was unannounced. The inspection was carried out by a single inspector.

Prior to the inspection we reviewed the information we held about the service including statutory notifications received from the provider about significant events that had taken place at the service.

During the inspection we met all six people using the service and spoke with four. We also completed general observations of staff interacting with people using the service. We spoke with three care staff, the acting manager and the Director of Operations.

We looked at three people's care records, three staff files, training records, audits and other records related to the management of the service.

We spoke with two relatives and following the inspection we contacted four health and social care professionals who supported people using the service for their views. Two of the health and social care professionals shared their views of the service with us.

Is the service safe?

Our findings

People who used the service told us they felt safe in their home. A relative also confirmed they were confident that staff at the service took action to keep their family member safe. However, we found that some improvements needed to be made to ensure that people's safety was maintained at all times.

People told us there were always enough staff to support them and to enable them to go out and take part in activities. There were four care staff on duty when we arrived at the service and the manager told us that there was always a minimum of four staff on duty during the day. The rotas we viewed confirmed this. One staff member said, "There's always enough staff on duty, even if someone cancels their shift at short notice." At night there were two staff members on duty, one waking night staff and one member of staff who slept in and was available in case the waking night staff needed support. The manager told us that extra staff were added to the rota to support planned activities and we saw that extra staff were working at the weekend to enable people to attend a local disco.

The manager told us that there were staff vacancies for a team leader, one or two senior care staff and two support workers and said that the majority of the staff team had only been employed at the service for a year or less. He acknowledged that this was having an impact on the service in terms of continuity of care for people and said that staff morale and sickness had been affected by the number of incidents at the service in relation to behaviour that was challenging. A health and social care professional we spoke with who worked closely with the service also told us that people at the service had not in the past always received one to one support as required because of staff shortages at the service but this was starting to improve. The manager told us that these posts were being actively recruited to and that in the meantime permanent staff were working extra shifts and bank staff who were familiar with the service were being used to cover any gaps wherever possible. One member of staff told us "We're in the process of building a team, as it gets bigger, it will get better."

There was a shift leader on each shift and a shift plan so staff were clear about their responsibilities on each shift. For example, individual staff took responsibility for particular appointments, medicines and supporting individuals on a one to one basis.

The provider had undertaken staff recruitment checks but these did not ensure all staff were suitable to work with people using the service. The staff recruitment files we viewed contained criminal record checks, proof of identity and two references from previous employers as well as a completed application form detailing the staff member's employment history. However, we noted that one staff member had stated on their application form that they didn't pass the probation period with a previous employer. Although this period of employment was not within the health and social care sector this still should have been explored with them to ensure that the reason for this did not impact on their suitability to work at the service. There was nothing in the staff member's file to indicate that the provider had carried out these checks. We also noted that one person had two references but both of these only stated the dates the staff member had been employed and did not provide any information about their suitability for their role. In another file we noted one reference had not been verified to ensure its authenticity.

These issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that safeguarding incidents were reported appropriately and action taken to ensure that people were protected from abuse. Staff understood their responsibilities in that they said they would report any concerns to a manager, however, not all staff were aware of what external agencies they could report safeguarding issues to. For example, two members of staff were not aware that they could report concerns to the Care Quality Commission (CQC). Staff did tell us about the provider's whistleblowing telephone line that they could call and report concerns affecting the welfare and safety of people using the service.

Risks to individuals using the service were assessed and detailed plans had been developed to inform staff about how to manage these risks whilst balancing the rights of people to make their own decisions. Risk assessments covered issues such as verbal and physical aggression, inappropriate behaviour, smoking, self-neglect and travel. However, in two instances it was not clear that risk assessments had been reviewed as people's needs changed.

Care records contained detailed behaviour support plans that had been developed with health and social care professionals and gave clear guidance for staff, but the information in these records was not very accessible as current support needs were not always recorded in one document and therefore it was difficult to see where people's needs had changed and any support plans had been updated. In addition staff were expected to sign care records to demonstrate that they had read and understood the guidelines in place but not all staff had. We noted that one person's records did not accurately reflect the work that staff had informed us was being undertaken with this person. This was concerning as physical intervention was used as part of this person's behaviour support plan and staff were not always effectively equipped to manage incidents in a safe and effective manner.

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

People using the service had complex needs and behaviour that challenged the service. Over the latter part of 2015 there had been an increased number of incidents. The reasons for this were not certain but there had been significant staff changes and safeguarding concerns relating to staff behaviour that may have contributed to this and the manager agreed that this was a likely cause. However, the concerns had been appropriately reported and investigated and at the time of our inspection the manager was able to inform us, and records confirmed that the number of incidents had begun to reduce.

An individual missing person's procedure and plan was in place for each person and people had access to an easy read guide about keeping safe at home, in the community and when travelling on public transport.

Environmental risks such as the storage of knives and cleaning products had been assessed and managed to protect people from harm. The fire risk assessment for the service had been reviewed in June 2015 and weekly fire safety checks were taking place alongside regular fire drills to ensure that people knew how to evacuate the building safely in the event of a fire. People had personal emergency evacuation plans in place to ensure that their individual needs were considered in the event of an emergency.

The provider had a business continuity policy and procedure which meant there were plans in place to respond to foreseeable emergencies. For example, plans were in place guiding staff about what to do in the event of a fire, flood, and structural failure of the building and an outbreak of an infectious disease. Although, this plan detailed a point of evacuation and general guidance for staff about the resources they

would need and the action they should take, it was not personal to the individuals using the service. For example, some people using the service found changes to their routine difficult to manage and therefore any evacuation to another property would potentially have a major impact on their wellbeing and their behaviour. This was not addressed in the plans. The manager told us he was looking into developing grab packs for emergencies with essential information about individuals.

Medicines were stored safely and people received their medicines as prescribed. A member of staff showed us the arrangements for storing medicines. There were two medicines cabinets, one for storing people's daily medicines and one that was used to store PRN (as needed) medicines. Each person was allocated a shelf in the medicines cabinet for storing their medicines so they were kept separately and each person had a medicines profile with their photograph to reduce the likelihood of any administration errors. We looked at the medicine administration records (MAR) for each person and saw that these were clear and fully completed. Where people had not been given their medicines there was a clear reason for this recorded. A record was kept of any medicines received from or returned to the pharmacy and the pharmacy carried out audits of the arrangements at the service to ensure these were safe. We saw the report from the audit and found that staff had addressed the recommendations made by the pharmacist one of which was to purchase a new medicines cabinet for the storage of the PRN medicines which were previously stored in a locked filing cabinet.

We saw that PRN protocols were in place that provided clear guidance to staff about when these medicines should be used, especially where these medicines were used in relation to behaviour that challenged the service. The guidelines were clear that these medicines were only to be used as a last resort and records clearly indicated that these arrangements were reviewed at regular intervals. People's care records also showed that their medicines were reviewed where required to ensure that they were prescribed the most appropriate medicines.

Is the service effective?

Our findings

People told us that staff supported them well and a relative commented, "They have their own psychologist now and they're working with [our family member]." However, we found that staff were not always equipped with the necessary skills and experience to enable them to meet people's needs effectively. This view was also reflected by health and social care professionals who supported people using the service.

The service had a relatively new staff team and many of the staff had yet to attend training in key areas to support them in their role. The manager was unable to give details of all the training that staff had attended during the inspection as this was held at head office. Following the inspection we were sent a central training matrix that listed all the training that had been attended. There was a wide range of training offered by the provider involving both e-learning and face to face training. Topics included the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards, fire safety, food safety, medicines awareness, disability awareness and equality and diversity. In addition, there was specific training available in relation to the needs of people using the service such as training about Autism and MAPA (managing actual and potential aggression) training.

However, the figures we saw showed that there were significant gaps in this training. For example, only eight out of 13 staff had completed food safety training despite all staff being involved in food preparation, only eight had completed MCA and DoLS training, only six out of 13 had completed medicines awareness training and only six had completed safeguarding training. We were particularly concerned about the numbers of staff yet to complete positive behavioural support, MAPA and Autism training as the people who used the service had complex needs and behaviour that challenged the service. It was important that staff attended this training to ensure they were able to confidently and safely meet people's individual needs and respond to behaviour appropriately. When we asked the manager about the training records he said that the figures were not accurate but acknowledged that there were gaps in training that they were trying to address. He said that it had been difficult for staff to attend training due to staff shortages. We also noted that not all staff had attended refresher training in areas such as food safety and medicines awareness as required under the provider's own policies.

We also found that there were inconsistencies in relation to how staff were responding to people's behaviour as not all staff were consistently following behaviour guidelines from healthcare professionals. In addition not all staff had received the appropriate training to ensure they were able to respond to incidents of verbal and physical aggression effectively in order to keep people safe.

The above information relates to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Two of the staff members we spoke with confirmed that they had completed training in medicines awareness, safeguarding and MAPA and said they had found the training helpful in supporting people who used the service. One commented that the Autism training helped them to understand that, "They (people using the service) don't see things the way you do." The manager told us that training had been planned for staff to attend including MAPA, Autism, person centred review, sexuality and epilepsy training and we saw

the dates for these displayed in the office.

All the staff we spoke with said they had received an induction to the service during which they had read policies and procedures, care plans and shadowed a senior support worker for five days before working independently. We saw that the provider had introduced The Care Certificate induction standards but we saw no evidence that this been implemented yet and records relating to staff induction were not always fully complete.

Staff told us that they received regular supervision with the manager and the records confirmed that staff were receiving supervision every one to two months. They said that supervision gave them the opportunity to discuss any concerns and improvements that could be made in terms of their own performance and that of the team. One staff member said, "[The manager] gives me a personal improvement plan if I'm slacking on something. ...it motivates you to do better." Another staff member commented, "I had [supervision] on Monday, it was useful."

An annual staff appraisal system was in place, however, many of the staff were new and had not yet been employed at the service for more than a year. We noted that two staff were slightly overdue their appraisal but there were plans in place to complete these.

The provider had an in house psychology team and worked closely with the local authority multi-disciplinary team of health and social care professionals to support people who had behaviour that challenged the service. Steps had been taken introduce a small team of two to three care staff to work with one individual to provide consistency and continuity of care and support more positive behaviour. Records showed that there was some analysis of people's behaviour on a monthly basis to check if the strategies being used were effective, however, these were not always fully completed.

We observed an incident during the inspection where a person using the service became very angry and upset. Staff managed this appropriately, remaining calm, listening to the person and offering reassurance that eventually helped to diffuse the situation. One member of staff commented, "We have to use positive reinforcement, not negative reinforcement" and another said "We don't want to use restrictions, we always try other things first." Records showed that incidents were recorded in detail and included a body map describing any physical intervention that had taken place.

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

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

We checked whether the service was working within the principles of the MCA and found that staff understood their responsibilities under the Act. Staff were able to demonstrate that that they always considered people's rights to make their own decisions and we observed staff offering people choices and respecting their wishes when they changed their mind about doing something. We saw that people had signed their consent to staff looking at their care plans, their inclusion in the provider's newsletter and photographs. Staff comments when asked about their understanding of the MCA included, "If someone is

unable to make their own decision, you need to support them to make it" and "It's when people need support to make the right choices to keep them safe."

Each person had a decision making profile that detailed how the person liked to receive information, how choices should be presented and how staff should support them to understand the choices available to them. This included using communication tools such as pictures and speaking clearly and slowly. However, we noted that best interests assessments were not always recorded in people's care files to demonstrate the decision making process where it was felt that people were unable to make a particular decision for themselves.

DoLS authorisations had been applied for and granted where it was felt that restrictions were required in people's best interests. For example, an application had been authorised to add key pads to the front and back doors of the property to prevent one person from leaving the service unaccompanied as this would pose serious risks to their safety. A DoLS authorisation had also been sought so that sharp knives could be locked away for people's safety.

People were encouraged to eat healthily and supported to choose what was prepared for the evening meal one day a week each. The menu for the week was then displayed outside the kitchen using pictures to support people's understanding. People told us that they could have something else if they did not want what was prepared and records confirmed this. We noted there was fresh fruit available for people to help themselves to and there were other snacks stored in the kitchen. There was plenty of fresh produce stored in the fridge and food was labelled with a date of refrigeration or opening to ensure these were discarded once no longer suitable to eat.

We saw that referrals had been made to a dietitian where staff had been alerted to concerns about people's diet and eating habits and dietetic assessments had taken place and staff were

People's health needs were assessed and responded to. Each person had a health folder that contained a health action plan and a hospital passport which contained information about the individual's needs so that medical staff were aware in the event of a hospital appointment or admission. We noted that these documents were not all up to date, however, the manager was aware of this and plans were in place to update these using a new recording format that would contain detailed accessible information about people's ongoing health needs. Records showed that referrals had been made to multi-disciplinary teams for specialist support, for example, when staff noticed that one person was starting to isolate themselves.

Records of appointments for routine eye tests and dental check-ups were seen and follow up action recorded for staff such as ways to improve a person's dental health. We also saw that easy read information was available to help staff explain the process of a dental check-up and the benefits of this. However, we did note some gaps in the recording which could have led to the risk of some appointments not being appropriately followed up.

We noted that the environment needed attention in terms of the décor which was tired and worn and did not look particularly well cared for. There were marks on the walls where items had been taken down, one of the sofas in the living room appeared broken in that the seat was leaning backwards and curtains were not hanging properly in both of the ground floor communal areas. Some communal areas had worn carpets. The manager and the operations director acknowledged this and told us that there were plans in place to extend the property to meet the support needs of one individual which would include extending the kitchen, redecorating and improving the staff sleeping in arrangements. We saw records that confirmed these plans.

Is the service caring?

Our findings

People told us that staff treated them well. Comments included, "he's my mate", "I like conversation", "I love staff" and "They are nice people." A relative we spoke with said, "We're as happy as we can be" and told us, "If there's anything we should know they let us know."

We observed positive interactions between staff and people using the service. For example, we saw staff talking with a person who was distressed in a calm and reassuring manner. We heard staff respecting people's choices and supporting people to participate in community activities of their choosing.

During the inspection one person came to speak with us and took us to the kitchen to proudly show us the chocolate cake baking in the oven that a member of staff had supported them to make.

We observed people completing household chores such as taking the rubbish out and tidying their room with the support of staff and we saw that goals and aspirations were included in people's care plans. Each person's care plan contained a section entitled 'Dreams for the future'. We could see that staff had discussed this with individuals and recorded their views. For example, one person's expressed an interest in exploring a career in transport and staff had ensured that activities such as train journeys were planned to meet this interest. We spoke with this person and they told us they were going out with staff on a train journey that day to buy a present for a member of their family as it was their birthday soon.

People had locks on their bedroom doors and were able to have a key to their room to protect their right to privacy; some people needed support with this and were given appropriate assistance from staff. We observed staff knocking on people's doors and waiting for a response before entering their rooms and the people we spoke with confirmed that staff always did this. We saw that risk assessments considered what action staff should take to protect people's dignity during incidents of inappropriate behaviour.

Care plans included people's preferences and likes and dislikes as well as what was important to them. There was information about their life history to support staff understanding of their backgrounds and current needs and information about what a 'good day' or a 'bad day' looked like so that staff could be responsive to this. We saw that people were supported to meet their spiritual needs. One person had been supported to attend church and staff were in the process of finding an alternative church for them to attend as they were no longer able to attend the one they had been going to previously. Discussions with staff also demonstrated that they had considered people's needs in relation to their sexuality and that steps had been taken to ensure that people were supported to make informed decisions that mitigated any risks to their safety.

People were provided with a guide to the service which was produced in an easy read format to help enable their understanding. We saw meetings of a meeting that had taken place with people using the service in September 2015 where people had been involved in discussions around planning for shopping, activities and household chores. The manager acknowledged that these meetings had not been taking place at regular intervals and we saw that plans were in place to ensure that people were involved in the day to day

running of the service.

People were referred to advocacy services as required to ensure that their voices were heard especially in relation to decisions about their care, support and accommodation.

Is the service responsive?

Our findings

People were at risk of their needs potentially not being met as care plans were not organised in a way that was easily accessible to staff to ensure they clearly understood how to meet people's needs.

People's needs were assessed prior to using the service and a care plan was developed to provide guidance to staff about how to meet people's individual needs. The care plans we saw were detailed and covered all aspects of people's care. However, the information was not always organised in a way that clearly outlined people's needs and the action staff should take. For example, the main care planning documents we saw were dated 2014, we saw additional documentation evidencing that these had been reviewed and updated outlining any changes in people's support but the original care plan had not been updated. Therefore it was difficult to tell what people's current needs were as not all of the information was in the same place. The healthcare professionals we spoke with also confirmed that although they were confident that the service was improving there were still issues with staff not always following people's care plans.

The manager acknowledged that the care plan documentation was complex but said that staff had two days training to ensure they knew how to navigate and use the care planning system. He said that agency staff were talked through behaviour support plans and risk assessments before they worked with people but told us that the provider was in the process of developing an overview of the care plan documentation that would be more accessible and given to agency staff and health and social care professionals who worked with people using the service.

People were supported to take part in activities they enjoyed. One person said, "I went to a disco yesterday and I'm going dancing later" and a relative told us, "[My family member] can go out when she wants." Records showed that a range of activities took place such as bowling, trips to the cinema and central London, a monthly disco and visits to local cafés and restaurants. The manager told us that one person had started to isolate themselves and that staff were exploring new activities for this person to try and combat this.

People had structured activity plans in place as for most people using the service routine was important. The manager told us that whiteboards were being introduced in people's rooms so that with the support of staff people could have a visual representation of their planned activities and appointments to help with their understanding and to enable staff to be more responsive in terms of providing structure and pictorial communication aids. We observed one person completing their whiteboard with the support of a staff member.

We saw that people were encouraged to develop and maintain independent living skills and were supported with household chores, cooking and travel on public transport.

People had communication plans in their care plans that detailed how they communicated and expressed their emotions and how staff should respond to this to help maintain people's emotional wellbeing.

Care plans contained details of relationships that were important to people and people told us that their friends and family visited them at home and that they were support to visit people too. One person said, "[My family member] visits me a lot."

We saw evidence that the manager listened to feedback from relatives. For example, in a recent survey a relative had commented that more could be done to help people celebrate events in their families. The manager had taken action to address this immediately and we saw that one person was going out shopping on the day of the inspection to buy their family member a birthday present. The person told us, "I'm going on a train today, going to buy [my family member] a present."

The provider had a complaints procedure that was produced in an easy read format and available to people using the service. When asked about complaints a relative commented, "If we've ever mentioned anything, they've soon sorted it out." We looked at the complaints records for the service, which included a complaint from a neighbour about noise and complaints from relatives. The records showed that the manager had investigated and responded to complaints promptly and taken action to address any identified areas for improvement.

We recommend that the provider seeks advice from a reputable source about care planning for people who use the service to ensure that documentation is accessible and supports staff understanding.

Is the service well-led?

Our findings

The service did not have a registered manager at the time of our inspection. The manager had been in post since July 2015 and had recently applied for registration with the Care Quality Commission but his application was still being processed at the time of the inspection.

The manager told us that he had inherited a service that was not operating effectively and that he was trying to implement changes to improve the service. However, he said that this had been difficult as there were staff vacancies for a team leader and senior support staff that were affecting the management and leadership of the service as he was finding it difficult to implement all of the necessary improvements without these team members. These posts were being actively recruited to at the time of the inspection. The manager told us that he had been offered support from the Operations Director and from the deputy manager from one of the provider's other projects and said this had helped.

Healthcare professionals we spoke with were confident about the current manager's commitment to improving the service and felt that improvements would be achieved. However, they commented that there were currently issues in terms of staff training and their capabilities in relation to meeting people's individual needs. We identified similar concerns at the inspection, and this required improvement.

The staff we spoke with made positive comments about the manager such as, "He has made us feel better" and "If I've got a problem I feel I'm comfortable to speak to him." Staff also confirmed that the Operations Director visited once a month and asked staff for their views and also attended staff meetings.

Internal audits were taking place to check how the service was operating and action plans were in place to address any shortfalls. A recent comprehensive audit covering all areas of the service completed in January 2016 had identified most of the shortfalls we found during the inspection and there were plans in place to address these. However, the issues we found in relation to recruitment checks had not been identified.

We also saw a service improvement plan which included a range of improvements including updating staff training, using psychology input to reduce the number of incidents, improving the timeliness of incident reporting and ensuring that staff followed behaviour support guidelines. There had been an acknowledgement that staff including the management team needed to be more reflective and learn from events that took place at the service to make improvements. We could see that work was already taking place to implement these improvements but it was too early to assess the outcome.

The provider had clear values including being outcome focused, treating people with dignity and respect, being honest, open and transparent, financially viable and offering choice independence and control for people using the service. We saw that the values had been discussed in a staff meeting in November 2015, however the minutes of this meeting were brief and it was difficult to tell how involved staff had been in any discussions around the operation of the service. A previous meeting had taken place in September 2015.

The manager told us that meetings, including meetings involving people and their families had not been

taking place as often as expected. However, a family meeting had been arranged for 23 February 2016 to ensure that relatives were kept informed about developments in the service and given the opportunity to share their views.

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 17 HSCA RA Regulations 2014 Good governance The registered person had not maintained an accurate and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person was not operating effective systems to ensure that persons employed were of good character and had the qualifications, competence, skills and experience necessary for the work to be performed by them. Regulation 19(1)(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of the regulated activity had not received appropriate training. Regulation 18 (2)(a)