Phoenix Learning and Care Limited

Number 14

Inspection report

14 Oak Park Villas
Dawlish
Devon
EX7 0DE

Tel: 01626864066
Website: www.oakwoodcourt.ac.uk

Date of inspection visit:
20 March 2018
22 March 2018
28 March 2018

Date of publication:
02 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 20, 22 and 28 March 2018. Number 14 is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Number 14 is registered to provide personal care and support for up to two young people who have a learning disability or autistic spectrum disorder. The home does not provide nursing care. At the time of the inspection there were two people living at the home.

Number 14 had two registered managers 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 home is run.

Number 14 had been developed and designed prior to Building the Right Support and Registering the Right Support guidance being published, we found it followed some of these values and principles. These values relate to people with learning disabilities living at the home being able to live an ordinary life.

The home's quality assurance and governance systems were not always effective. The provider used a variety of systems to monitor the quality and risk at the home. Although some systems were working well, others had not identified the concerns we found during this inspection.

Risks to people's health and wellbeing were not always managed safely and the systems in place to manage risk could not be relied upon. We found some risks such as those associated with people's complex needs or the environment had not always been assessed or managed safely.

The provider did not have a systematic approach to determine the number of suitably qualified and competent staff required to meet people's needs. This had led to one person being left on their own and some staff not receiving the necessary training to carry out the role required of them.

We checked whether the home was working within the principles of The Mental Capacity Act 2005 (MCA). We found the home was not taking appropriate action to protect people's rights. For example, where the home restricted or managed people's access to the internet or mobile phone usage. There were no mental capacity assessments to show that people did not have capacity to manage their own use of the internet or mobile phones. There were no records to show the rational for these decisions, or whether this was being carried out in their best interests.

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. People received their medicines when they needed them and in a safe way.

People were cared for and supported by staff who knew them well. Both registered managers and staff understood their roles and responsibilities to keep people safe from harm and protect people from discrimination.

People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated. People's support plans contained detailed information about people's hobbies and interests. Staff explained how they empowered people to manage their own needs independently and supported them to be as independent as possible with the planning, shopping and cooking their own meals.

People were aware of how to make a complaint and felt able to raise concerns if something was not right and people were encouraged to share their views. We received mixed views about the management of the home. Some relatives and healthcare professionals told us the home was well managed, and described the management team as open, honest and approachable. While others did not know who the registered managers were. Both registered managers were aware of their responsibilities in ensuring the Care Quality Commission (CQC) and other agencies were made aware of incidents, which affected the safety and welfare of people who used the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the home were not always safe.

Risks to people's health, safety and well-being were not always being effectively assessed, managed or mitigated.

People were not always protected from the use of punitive practices.

There were insufficient numbers of skilled and experienced staff to meet people's needs.

The provider did not have a systematic approach to assessing staffing.

Safe and robust staff recruitment procedures helped to ensure that people received their support from suitable staff.

Staff were aware of how to identify and respond to allegations and signs of abuse and how to raise any concerns.

People received their medicines as prescribed. The systems in place for the management of medicines were safe and protected people who lived at the home.

Is the service effective?

Requires Improvement

The home was not always effective.

The principles of the Mental Capacity Act 2005 had not been followed in relation to obtaining consent and best interest decisions.

The provider had not ensured staff received the necessary skills required to carry out their duties.

People were cared for by staff who received regular supervision, and were knowledgeable about people's needs

People's health care needs were monitored and referrals made when necessary.

People were supported to maintain a balanced diet.

Is the service caring?

Requires Improvement

Some aspects of the home were not always caring.

People's privacy and dignity was not always respected or supported by staff.

People were involved in the planning of their care and were offered choices in how they wished their needs to be met.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Good

The home was responsive.

People's care plans were personalised with their individual preferences and wishes taken into account.

People enjoyed a variety of social activities.

People were confident that should they have a complaint, it would be listened to and acted upon.

Is the service well-led?

Requires Improvement

Some aspects of the home were not well led.

Although quality assurance systems were in place, they were not being used effectively or undertaken robustly enough to identify the issues seen during the inspection.

People's care records were not always accurate or kept up to date.

There was an open, transparent culture and staff felt supported by the homes management team.

The home had notified the CQC of incidents as required by law.

Number 14

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 home, and to provide a rating for the home under the Care Act 2014.

This comprehensive inspection took place on 20, 22 and 28 March 2018. The first day was unannounced; this meant the provider did not know we were coming. The inspection team consisted of one adult social care inspector.

Prior to the inspection, we reviewed the information we held about the home. This included statutory notifications we had received. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the home, what the home does well and improvements they plan to make.

During the inspection, we met both people living at the home as well as two members of staff, both registered managers and the nominated individual. A nominated individual is the provider's representative and is responsible for supervising the management of the regulated activity provided. We also spoke with one of the directors and the Chief Executive. We asked the local authority who commissions the home for their views on the care and support given at Number 14. Following the inspection, we received feedback from two healthcare professionals and two relatives.

To help us assess and understand how people's care needs were being met, we reviewed two people's care records. We looked at the medication administration records and systems for administering people's medicines. We also looked at records relating to the management of the home: these included four staff recruitment files, training records, and systems for monitoring the quality of the services provided.

We used elements of the short observational framework for inspection tool (SOFI) to help us make judgements about people's experiences and how well they were being supported. SOFI is a specific way of observing care to help us understand the experiences people had of the care at the home.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm because the systems in place to manage risk were not always effective. We found some risks, such as those associated with people's complex care needs and the environment had not been identified or insufficient action had been taken to mitigate these risks.

When we arrived at the home, we found one of the people living at Number 14 had been left on their own. We looked at this person's individual risk management plan and found this person had been identified as being a risk to themselves and others. They had been assessed as needing staff support and supervision at all times. This meant staff had potentially placed this person and others at risk of harm. We discussed what we found with one of the registered managers who took immediate action to ensure this person was properly supported in line with their current risk assessment.

Systems in place to manage risk were not effective. The home used a centralised computer management system called "behaviour watch" to record incidents that had taken place. One of the registered managers told us the purpose of the system was to record all incidents in one place. This information was used to update people's individuals risk management plans. We spoke with a senior manager about one of the people living at the home who told us this person had been involved in approximately fifty incidents since coming to live at the service. We found the system only contained details for seven incidents. This meant the system did not provide staff with accurate information about these incidents and any associated risk, and therefore could not be relied upon.

People were not always protected from the risk of harm as they were living in an environment that may not be safe. When we walked around the home, we found a number of bedroom windows were not properly restricted. We found window restrictors could be easily removed as staff had not removed the locking keys. We brought this to the attention of the one of the registered managers who arranged for the keys to be removed.

We reviewed the home's fire safety precautions. The provider had a Fire Risk Assessment in place, which is a legal requirement under The Fire Safety Order. Upon reviewing this document, we found it did not identify or reflect all the risks associated with the environment. For example, it did not identify the boiler room did not have smoke detection or that there was lone working taking place at night. Records showed routine checks on fire and premises safety were taking place; however, it was unclear what staff were testing. This meant the provider did not have in place an effective system to ensure they had identified all fire hazards, or reduce the risks of those hazards causing harm. One of the registered managers assured us they would provide guidance for staff in relation to the testing of equipment and arrange for the Fire Risk Assessment to be updated. Following the inspection one of registered managers confirmed that smoke detection had now been fitted in the boiler room.

We asked one of the registered managers and the nominated individual to tell us who had keys to the home. They explained the lock to the front door, and the staff office where people's confidential information and medicines were stored, was part of a master key system. They said all staff working locally (in the college or

in the home) would have been issued with a master key upon their employment. This meant the registered managers were not aware how many staff working for Phoenix Learning and Care Limited (Oakwood, Oakwood College) could gain access to the home and people's bedrooms, unnoticed and unchallenged. This put people's safety, their belongings and the security of the building at risk. When we returned for the second day of the inspection, one of the registered managers advised us that the locks to Number 14 had been changed and now only staff working at the home has access to the home.

The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the use of punitive practices. We reviewed people's care records and found one person living at Number 14 had in place a document called a 'Reward Chart'. The guidance relating to this stated '[person's name] is to behave appropriately and follow staff's instructions if [person name] shows good behaviour in both college day and residential [person name] will be rewarded with a treat.' On one occasion records showed this person's [inappropriate behaviour] had led to them not going on a trip. This seemed to indicate the person had to earn trips out or drinks they enjoyed rather than them being a part of normal everyday life.

This person's care and support plan did not provide a clear rational as to why it was necessary to have a 'Reward Chart' in place or provide guidance for staff to identify what appropriate behaviour looked like. Without guidance, the system in place was potentially open to abuse, as staff may not understand what was expected from them. When we asked senior staff, why it was necessary to have the 'Reward Chart' in place both registered managers were unable to tell us when or who had implemented the reward system and removed it with immediate effect.

Failure to protect people from abusive practices and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff on duty at all times to meet people's assessed needs. When we asked people if there were enough staff to meet people's needs and keep them safe, one person said, "I never know if someone should be here or not." One of registered manager told us there were enough staff on duty to meet people's assessed needs, provided they went to college. They explained the system used to determine staffing levels did not allow for staffing between the hours of 9.30 am 3.30 pm Monday to Friday as people were at college. We asked what would happen if people did not attend college, for example if they were ill or simply did not want to go. One of the registered managers said, the college would send one of the learning support assistants to check on them regularly throughout the day.

The provider did not have a systematic approach to determine the number of staff required to meet the needs of people living at the home and keep them safe at all times. This was a breach of Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse. Staff told us what action they would take if they suspected a person was at risk of abuse and had a good understanding of their role in protecting people from harm. Staff demonstrated they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected.

People were protected by safe recruitment processes. Systems were in place to ensure staff were recruited safely, and were suitable to be supporting people who might potentially be vulnerable.

We looked at four staff files, which showed a full recruitment process had been followed which included obtaining disclosure and barring service (police) checks.

People received their medicines when they needed them and in a safe way. People's medicines were administered and disposed of appropriately and securely. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way. Staff told us they had received training in the safe administration of medicines and records confirmed this. We checked the quantities of a sample of medicines against the records and found them to be correct.

Where accidents had occurred these were recorded, including information about the time, location and who was involved. This was so registered managers could review the information and take appropriate action to reduce any re-occurrence. Each person had a personal emergency evacuation plan (PEEP) and the provider told us they had contingency plans to ensure people were kept safe in the event of an emergency.

The home was clean, staff were aware of infection control procedures, and had access to personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection. There was an on-going programme to redecorate and make other upgrades to the premises when needed. Equipment owned or used by the home were suitably maintained. Systems were in place to ensure equipment was regularly serviced and repaired as necessary. Appropriately, skilled contractors had completed all necessary safety checks and tests.

Requires Improvement

Is the service effective?

Our findings

People's ability to make decisions had not been assessed, or recorded in a way that showed the principles of the Mental Capacity Act, 2005 (MCA) had been complied with.

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 people 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's support plans did not demonstrate their consent and / or views had been sought in relation to decisions being made on their behalf, or that they did not have capacity to make some decisions that were being made on their behalf. This indicated the home was not working in line with the principles of the act. For example, people's access to the internet and their mobile phones was being restricted. Staff told us this was because it was important people had a good night's sleep without distractions. There were no mental capacity assessments to show that people did not have capacity to manage their own use of the internet or mobile phones. There were no records to show the rational for these decisions, or whether this was being carried out in their best interests.

Records for one person showed staff were regularly making the decision to share their personal and private information with Oakwood College without involving them or seeking their consent. There were no records to show the rationale for this decision, no mental capacity assessment to show that the person did not have capacity to consent to the sharing of information or that this was being carried out in the person's best interest. We spoke with one of the registered managers who was unable to tell us if the person was aware that their information was being shared or why it was being shared.

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). One of the registered managers had made an application to the local authority to deprive one person of their liberty in order to keep them safe. We found the person's capacity to consent to care and support had not been assessed prior to the application to deprive them of their liberty being made and there was no evidence that a best interests meeting had taken place

We raised our concerns with one of the registered managers who agreed that people's records did not contain sufficient information to demonstrate the home was working within the principals of the MCA. The registered manager assured us they would take action to address this.

Failure to gain consent from people, or where people were unable to give consent, involve relevant health or social care professionals in best interest decisions is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had confidence in the staff supporting them and relatives told us they felt staff were well trained. Healthcare professionals were confident staff had the right skills and were knowledgeable about the people they supported. One healthcare professional said, "I have found everyone I have had communication with extremely professional and knowledgeable."

The system in place to ensure the management team could judge that staff had the necessary skills to carry out their duties was not effective, because the record of staff training and training updates was not up to date. Following the first day of inspection, we were provided with a copy of the home's updated training matrix. This showed staff had completed training in medication, first aid, fire, food hygiene, equality and diversity, Mental Capacity (MCA), Deprivation of Liberty Safeguards (DoLS), and safeguarding of vulnerable adults. As well as, more specialist training in Autism, epilepsy, pathological demand avoidance syndrome and total communication.

The training matrix provided to us identified significant gaps in the training staff had received. For example out of a core team of five, three of the staff employed had not completed safeguarding children training. Two staff had not completed training in Autism and only one member of staff had completed training in challenging behaviour, undertaken in 2013.

Number 14 is registered to provide services to children aged 13- 18 years. Staff told us that both of the people living at home could at times display behaviours, which may be seen as challenging and were on the autistic spectrum. We discussed what we found with one of the registered managers and nominated individual who told us that following a recent audit it had been identified that some people's training had lapsed and they were in the process of addressing this. They were not aware that two members of staff had not completed their safeguarding children's training and assured us that both members of staff would complete this training before their next shift.

Failure to provide staff with the appropriate training, necessary for them to undertake their role is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Newly appointed staff undertook an induction programme, which followed the Care Certificate framework. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Staff told us they completed an induction when starting work at the home. This included a period of orientation at the home; time spent reviewing policies and procedures; shadowing colleagues who were more experienced, and developing their understanding of the individual support people required.

Records showed staff received regular supervisions and annual appraisals. Staff told us they felt supported in their role. All staff felt there was an open door policy where they could approach the manager or senior staff at any point for advice, guidance and support. Staff felt they worked well as a team, and told us they all had different skills and experiences, which they used to support each other. One member of staff said, "[registered manager's name] is always at the end of a phone I can't praise them enough, they go the extra mile for all of us."

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. People's support plans included details of their appointments and staff we spoke with knew people well. Staff monitored people's mental and or physical health and we saw, where concerns had been identified; people were referred to or reviewed by an appropriate healthcare professional.

One of the registered managers told us that in addition to people being able to access local health care services people were supported internally by the provider's counsellor, speech and language therapist or behaviour support coordinator.

People were encouraged to be as independent as possible with planning, shopping and cooking their own meals. A large kitchen was freely accessible and well stocked with tea, coffee and soft drinks. Staff supported people to cook their evening meals individually. Staff knew people's food preferences well and told us how they supported people to follow a healthy balanced diet but explained how this could also be difficult to balance with people's preferred choice.

Requires Improvement

Is the service caring?

Our findings

We saw some positive interactions between staff and people living at the home. We also saw that staff did not always understand or respect people's right to privacy.

On the first day of the inspection, we saw several people let themselves into the home without knocking or using the doorbell and did not have a valid reason for their visit. For example, we saw one of the tutors from Oakwood College had let themselves into the home without knocking or ringing the doorbell and went up to a person's bedroom. They had come to check on the person, as they had not attended college. Shortly afterwards, we observed two Oakwood College staff being given a guided tour of the premises as part of their induction, they also entered the home without knocking or announcing their arrival. This demonstrated that staff did not see Number 14 as people's home and how their actions could impact on people's privacy and dignity.

We asked one of the people living at Number 14 how they felt about people coming into their home. They said, "It gets really annoying having people you don't know just coming in and out knocking on your door." We discussed what we saw with both registered managers and the nominated individual who said that they were unaware this was routinely taking place and took action to prevent this happening in future.

Some staff had recorded some information, which did not show they respected the people they were providing care for. For example, we saw a staff member had recorded in one person's notes, following a recent visit to the doctor, that they had asked [person's name] to leave the room so they could speak with the doctor about another matter. When the person left the room, they discussed matters relating to the person they had asked to leave. This personal information was then shared with senior managers at both the residential home and college without the person's knowledge or permission.

Failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Both people we saw were relaxed and happy in staff's presence. People told us they were actively involved in making decisions about their care and support. One person said, "I make choices every day about what I want to do or how I spend my time."

People's needs in terms of their mental and physical health, race, religion and beliefs were understood and supported by staff in a professional and non-discriminatory way. Staff supported people to make choices even when this was difficult, for example with relationships or behaviours, which might have a negative impact on themselves or others.

Staff were supportive, caring and showed genuine fondness and positive regard for the people they supported. When staff spoke with us about people, they did so in a respectful and compassionate manner. Staff told us how much they enjoyed working at the home. Comments included "it's a good place to work" and "people come first."

Staff were knowledgeable about the people they supported. Staff were able to tell us about people's background/histories and events which had shaped their lives, as well as their goals, aspirations and what was important to them now. Managers and staff told us they understood and recognised people's individual needs and worked alongside people in a positive way to help them identify triggers that might impact on their lives and learn how to manage these in the future. For instance, poor sleep patterns, social isolation or inappropriate behaviours.

Staff were familiar with people's individual communication methods and used this knowledge and understanding to support people to make choices and have control over their lifestyle. Staff told us how they supported people to be as independent as possible and recognised that it was important that people were able to gain new experiences and take risks. Each person had a key worker who supported them to develop their everyday living skills as well as new interests. Staff recognised what was important to people and encouraged people to challenge themselves.

Good

Is the service responsive?

Our findings

People, relatives and staff told us people were involved in identifying their needs and developing their care and support. People's needs were assessed prior to coming to live at the home. This formed the basis of a support plan, which was further developed after the person moved in and staff had got to know the person better. One of the registered managers told us this pre-admission assessment was carried out as part of the person's EHC plan. An education health and care plan (EHCP) is for children and young people aged up to 25 who need more support than is available through special educational needs support.

People's care and support records contained detailed information about people's health, education and social care needs. They were written using the person's preferred name and reflected how the individual wished to receive their care. Each person's support plan contained a one-page profile; these were designed to provide staff with all the important information about a person under three simple headings. 'What people appreciate about me', 'What is important to me' and 'How to support me'. This provided staff with important information to enable them to build positive relationships and help them understand what really matters to people and how they wish to be supported to live their lives.

Each section of the care and support plan covered a different area of the person's care needs, for example, personal care, physical health, independent living skills, healthy eating, communication, mental well-being and emotional support, medication and managing risks. People's wishes and unique goals were central to the care and support provided and there was an understanding that staff were there to enable and support people to manage their own behaviour/wellbeing and to develop life skills.

People's support plans guided staff on how to support people in managing their own behaviour and/or anxieties in a way which caused the least amount of distress to the person, or others. Support plans contained detailed information on the signs and triggers that might indicate that the person was anxious or upset as well as any action staff should take to support the person during these times. For example, one person's support plan described the types of events which may provoke feelings of anxiety or frustrations, such as unforeseen changes, not being listened to or being 'nagged at'. Staff were provided with guidance in how diffuse the situation.

The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment, or sensory loss. All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. CQC have committed to look at the Accessible Information Standard at inspections of all homes from 1 November 2017.

The manager was aware of the Accessible Information Standard and we saw that people's communication needs were clearly recorded as part of the home's assessment and care planning process. This information was then used to develop communication plans, which indicated people's strengths, as well as areas where they needed support. For example, each person's care plan contained a section entitled 'Things you need to communicate with me' and 'How I communicate with others'. This helped to ensure people's communication needs were known and met.

The provider had also developed communication toolboxes, which staff could use to support people to communicate and understand information using symbols and pictures.

Records showed people had signed their support plans. People and staff told us they had contributed to their development and were aware of their content. People and their relatives, where appropriate, were involved in reviews and were able to express their views about the care and support they received. We saw people's needs were reviewed on a regular basis with external professionals. However, it was not always clear how this information was recorded, who was involved or how this information was being used to develop and shape the care and support people received. For example, one of the people living at Number 14 was transitioning between services. The provider employed a full-time transitions coordinator who worked closely with people, their families, education partners and other providers to help ensure transitions were as smooth and supported as possible. The registered managers did not always attend these meetings. Records we saw did not show how the home was supporting this person with their transition in line with what had been agreed outcomes of these meeting. We spoke with the one of the registered managers, who explained they were starting to develop a plan that would involve a reduction in staffing to promote the person's independence, but nothing had been formalised yet as it was still early days. The registered manager was unaware that this person had already visited their new provider and had stayed overnight.

People's bedrooms reflected their individuality and particular interests and were personalised with photos, posters and bedding of their choice. For example, we saw one person had decorated their bedroom with posters of trains, as this was something they were passionate about. People's support plans contained detailed information about people's hobbies and interests. We saw people had many different opportunities to socialise and take part in activities. During the day people attended college however, after college people routinely went to a variety of clubs, pubs, night clubs, the cinema, or out for meals if they wished to do so. For example, one person told us about their passion for rugby and regularly played and watched their local team. Staff told us there were many opportunities for people to get involved, from taking part in sports such as swimming, archery, table tennis or box fit or getting involved in the local youth club 'Red Rock' where they could learn to DJ, socialise and meet new people. People were encouraged and supported to gain valuable work experience and we saw one of the people living at the home had a part time job working at a local café.

People were aware of how to make a complaint, and felt able to raise concerns if something was not right. The home's complaints procedure provided people with information on how to make a complaint and was available in easy to read format with pictures and photographs of who to talk to. One person told us when they had been unhappy they had made formal complaint to the manager. We look at this complaint as part of inspection and found that both registered managers had been involved investigated the person's concerns and provided a response.

Requires Improvement

Is the service well-led?

Our findings

The home was not always well led. We received mixed views about the management of the home. Some relatives and healthcare professionals told us the home was well managed, and described the management team as open, honest and approachable. While others did not know who the registered managers were. One relative said they were not sure who the manager of the home was. They said they felt that standards had "slipped."

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided. The provider used a variety of systems to monitor the home. These included a range of meetings, audits, and spot checks, for instance checks of the environment, medicines, infection control, health & safety, and accident and incidents.

Although some systems were working well, others had not been effective, as they had not identified the concerns we found during this inspection. For instance, although people's care was reviewed on a regular basis the outcomes were not always recorded and the systems in place to monitor people's care records were ineffective. This had led to the introduction of a 'Reward Chart' system without the knowledge of senior staff or the registered managers.

Systems in place to manage risk were not effective, as they could not be relied upon to provide staff with complete or accurate information of a person's risks.

The provider did not have a systematic approach to determine the number of staff required to meet people's needs. This had led to one person being left on their own, as there were no staff available to support them.

We found there was insufficient management oversight to ensure people received the care and support they needed, in a respectful and dignified way that promoted their wellbeing and protected them from harm. Where staff displayed poor practice this was not always known or challenged by senior staff.

The home was not working within the principles of The Mental Capacity Act 2005 (MCA) and found the systems in place had not identified that the home was not always taking appropriate action to protect people's rights.

The home did not have effective systems in place to assess or to monitor staff competence and skills to carry out the role required of them. This meant registered managers could not be assured staff had the necessary skills and knowledge to meet people's assessed needs in safe way.

People may not be protected from the risk of harm as they were living in an environment that may not be safe. Whilst some premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated.

Throughout the inspection, senior staff were open, honest and transparent. Whilst they had not been aware of all the concerns we identified they were aware of the need to improve. We met with the nominated individual and one of registered manager following the inspection, and discussed what we had found. They accepted and recognised the home needed to make a number of changes to improve the quality and support being provided. They said following an external audit completed in November 2017 that they were in the process of putting together a service development plan. We requested a copy of this plan but did not receive it.

Failure to ensure systems were effective in assessing, monitoring and improving the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were encouraged to share their views and were able to speak to the registered managers or members of the senior management team if they needed to. Relatives told us the communication with staff and managers within the residential home was poor. One relative said "It can be a constant struggle to get hold of people and I often have to rely on [person name] to tell me, how they have been or what they had been up to which is not an ideal situation to be in."

The management team told us their vision for the home was to create a safe and supportive environment that aims to empower people to take responsibility for managing their own behaviours and move towards independent living. Staff spoke passionately about their work and the people they supported and were proud of people's achievements.

Staff told us they enjoyed working in the home and felt supported by the management team. One staff member said, "I think [registered manager's name] is brilliant. Everything is dealt with efficiently and they're always at the end of the phone." Another said, "They're both very approachable if you need anything all you have to do is ask."

The management and staff structure provided clear lines of accountability and responsibility. Staff knew who they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns.

Records showed the registered managers and provider held regular staff meetings. Staff meetings were used to discuss and learn from incidents, highlight best practice and identify where any improvements where needed. For instance, we saw from these meetings registered managers had discussed concerns relating to people's care needs, medication, infection control, confidentiality and activities.

Feedback was sought from people, relatives, health, and social care professionals as part of the quality assurance process. There were a variety of ways in which people could give feedback. These included annual surveys, residents' meetings, care reviews and through the complaints process.

Both registered managers kept their knowledge of legislation up to date by using the internet and attending training sessions. They were aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm and had notified the Care Quality Commission of all significant events, which had occurred in line with their legal responsibilities.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People's right to privacy was not always respected or understood by staff. 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. Regulation 12(1)(2)(a)(b)(d)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Care and treatment was provided in a way, which intended to control a person's behaviour which was not proportionate to the risk of harm. Regulation 13(4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems and processes in place to assess, monitor, and mitigate risks to people. Records were not accurate, up to date, complete, or maintained securely at all times. Regulation 17 (1)(2)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers skilled staff employed to meet people's needs. The provider had not ensured staff received the necessary skills required to carry out their duties. Regulation 18 (1)