Truecare Group Limited

Fountain View

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was carried out on 15 and 16 July 2015 and was unannounced.

Fountain View provides accommodation and personal care for up to six people who have learning disabilities. At the time of our inspection six people were using the service.

Fountain does not have a registered manager in post. The registered manager was moved to another service a few weeks prior to the inspection. The deputy manager left the service a week before the inspection. At the time of our inspection an acting manager from another service was in managerial charge of the home. 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.

Risks were not always accurately and appropriately assessed. Risk assessments were in place for each person on an individual basis. However, there was an overuse of

Summary of findings

risk assessment and risk management planning that could be seen as restrictive, in some cases, whilst in others, risk assessments did not reflect all the known and assessed risks.

Restrictive practice was evident within the home. For example the kitchen had a coded door entry, as did the laundry. The fridge was in a cupboard with a lock and there was an alarm on doors at the top of the stairs which staff had to continually deactivate. People's rooms were locked but not everyone had a key to their room. There were no risk assessments around these restrictions. The physical intervention book contained evidence that restraint had been used inappropriately on occasions.

There were enough staff on duty to meet people's needs. Disclosure and Barring (DBS) checks were carried out before anyone could be recruited. However, we found that full employment histories had not been obtained. This meant that the provider could not be assured that staff recruited were suitable employees as they had not obtained a full employment history prior to recruitment.

Staff had received safeguarding training and were able to describe sources and signs of abuse and potential harm. They also knew how to report abuse.

Medicines were administered safely by staff who had been trained to do so. Staff had received medication training and had their competency to administer medicines checked. Medicines were stored safely in a locked cabinet.

People were asked for consent before care and support was provided. Staff told us they asked for consent before providing personal care and would do this in a way which people understood. Where people lacked capacity to make specific decisions, the provider should have acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). We found that although staff had received training in the MCA and were able describe the principles, the principles of the MCA were not being followed within the home.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that applications had been made without due regard to mental capacity. We also found there were deprivations within the home which were not the subject of DoLS applications such as locked doors.

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed that training covered all essential areas such as medication, food hygiene and fire safety. There was also training about positive behaviour support and specialist training.

People were offered a choice of nutritional food. People were not aware of the menu for the day, without having to ask, because the menus were not displayed on a noticeboard in an accessible way. People were offered some choice of food at mealtimes. Staff told us that drinks and snacks were available whenever people asked for them. People were unable to help themselves to drinks and snacks as the kitchen was kept locked.

Health professionals were appropriately involved in people's care. Records showed that health needs were met. One person received monthly health checks. Comprehensive health logs were kept within people's care plans, including appointments such as dental appointments. Psychologists were involved in people's care.

Staff were supportive and caring and treated people with high regard. Staff showed that they understood people well, describing individuals progress at the home.

People were encouraged to make decisions about their care and these were evident on a daily basis with people choosing when they got up, what they ate and what they did. They were involved in decisions about their medicines and had signed their medicine support plans.

The atmosphere in the home was caring. We observed people were supported in a positive, caring way. Staff communicated well with people and role modelled behaviour reinforcing support recorded in support plans. Staff were seen laughing and joking with people in a positive way. People were seen to be looking after each other as if they were a family. People who were more able looked after those who were less able.

People's views about their care were sought through regular one to one meetings with their keyworker.

Summary of findings

Privacy and dignity was respected. We observed staff knocking on people's doors before they entered. One person told us he would like to be more independent, but this was not supported in the home.

Some support plans were well written, clearly demonstrating how they met people's needs, whilst others lacked detail in relation to content and accuracy. Although the support plans lacked information, staff demonstrated that they knew people and were able to meet their needs.

Relatives and people told us they knew how to complain. There was not a clear reporting line for staff to raise concerns at the time of the inspection.

There was a positive culture in the home, even though there was no registered manager at the time of the inspection and the deputy had recently left at short notice. During this period of transition the provider had appointed an interim manager from another home. The interim manager was extremely knowledgeable about systems and processes and inspired confidence.

Records showed that several incidents should have been reported to CQC as a potential safeguarding but were not. For example threats to self-harm, allegations of abuse against staff, behaviour which put other people using the service at risk and choking.

There were systems in place to enable the service to deliver high quality care. Audits included health and safety weekly checks, infection control, expert (peer) audits and provider monitoring visits.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risk assessments were not always accurate and appropriate.

There was evidence of restrictive practice within the home. It was not clear that this was always appropriate.

Staff knew how to keep people safe from harm and protect them from abuse.

Staff rosters were planned to ensure there were enough staff to meet people's needs.

It was not clear that the required pre-employment checks had been completed for all staff which mean there was a risk that staff were not suitable for the role.

Medicines were administered safely by staff who had been trained to do so.

Is the service effective?

Requires improvement

The service was not always effective.

People received care and support from staff who had been appropriately trained and who had knowledge about people's needs.

People had access to suitable hydration and nutrition.

People were supported to make their own decisions, but where they did not have capacity the provider had not complied with the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not always caring.

The staff promoted an atmosphere which was kind and friendly.

Even though people were treated with respect and dignity, independence was not always promoted for all people.

Is the service responsive?

Requires improvement

The service was not always responsive.

Even though some support plans contained out of date and inaccurate information staff demonstrated they knew how to meet people's needs.

People and relatives knew how to complain, but due to the lack of a registered manager, staff did not have a clear way of raising issues, due to recent management changes.

Appropriate action was taken in response to people's health needs.

Summary of findings

Is the service well-led?

The service was not always well led.

There was no registered manager and the deputy manager had recently left with short notice. There was no permanent management in the home.

Despite this, there was a positive culture in the home.

People were encouraged to be involved in the future development of the service.

Learning from incidents could not be demonstrated, so it was not clear how improvements could be made.

Effective quality assurance systems were in place, to ensure a continuous and consistent quality of care.

Requires improvement

Fountain View

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 checked 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 was carried out on 15 and 16 July 2015 and was unannounced. The inspection was carried out by an inspector and a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge. In this case their skills and knowledge were with people who are living with a learning disability.

Before the inspection, we reviewed all the information we held about the home including the previous inspection reports and notifications received by the Care Quality commission. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service. This is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make.

During our inspection we spoke with two relatives and six people. We also spoke with the acting manager, the assistant area director and two support staff. We reviewed records relating to the management of the home, such as audits, and reviewed two staff records. We also reviewed records relating to six people's care and support such as their support plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences, we used other methods to help us understand their experiences, including observation. We used information in people's communication support plans to communicate with people effectively.

We last inspected the home in August 2013 and found no concerns.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Relatives told us their family members felt safe. One relative, when asked if their relative felt safe, said "Yes, it's the best home he's been in. He's secure, confident and happy." However, safe practice was not always demonstrated in the home.

Risks were not always accurately and appropriately assessed. Risk assessments were in place for each person on an individual basis. However, there was an overuse of risk assessment and risk management planning that could be seen as restrictive, in some cases, whilst in others, risk assessments did not reflect all the known and assessed risks. One person's risk assessment stated that their mood should be assessed before they were granted access to the community. This was not carried through to their care plan. This practice could be seen as restrictive, effectively denying the person access to the community unless they were in the 'right mood.' There was little to show the use of other professionals to support a proactive and preventative approach to support people with their presenting risks. Plans were very reactive and based upon managing presenting risk as opposed to supporting staff to support behaviours in a safe way, enhancing community access and helping people to move on in their lives.

Not all risk assessments were personalised. Everyone had a risk assessment stating that they should not have caffeine after 5pm. This was a blanket risk assessment and an example of restrictive practice in the home. It could not be demonstrated that this was a risk for everyone. There was no clear link between noted behaviours and risk assessment. For example, when a person demonstrated a new behaviour, there was not always a matching risk assessment to mitigate the new behaviour and advise staff how to deal with it. The provider had not explored potential causes of behaviour which could lead to a reduction in the behaviour and improvement in quality of life. Whilst some risk assessments were up to date and helpful, there were a number of needless risk assessments within people's care plans. Some risk assessments were up to date, accurate and supportive to the person. For example, one person had a risk assessment in relation to choking. Following a recent choking incident further guidance had been sought and staff were observed to be following it. One person's risk assessment and behavioural support plan had been recently rewritten. It reflected the long term nature of known behaviours. The risks were well conceived reflecting the pattern of risk and behaviour. Whilst some risk assessments were appropriate other risks were sometimes assessed inappropriately leading to restrictive practice, such as restricting everyone's intake of drinks containing caffeine after 5pm.

Restrictive practice was evident within the home. For example, the kitchen had a coded door entry, as did the laundry. The fridge was in a cupboard with a lock and there was an alarm on doors at the top of the stairs which staff had to continually deactivate. People's rooms were locked but not everyone had a key to their room. There were no risk assessments around these restrictions. There was evidence that some of these restrictions had led to people behaving in a way which may challenge others. One person had been told they were not allowed chocolate before dinner. There was no evidence that the person's capacity to make this decision for themselves had been assessed. Staff refusal had led to enhanced behaviours and a restraining incident. Another person was told they had to put a shirt on underneath their coat before they could go out. This similarly let to further incidents of behaviour which may challenge others. One person's care plan stated that they were not restricted from going anywhere; however they were not able to enter the kitchen, access the fridge, the laundry or go upstairs without an alarm going off.

A physical intervention log book was used to record incidents. This should have recorded all incidents where physical intervention was required. These should have linked to individual behavioural observation charts (BOC) and people's positive behaviour support plans. We found inconsistencies between these three records and some evidence that restraint was used inappropriately. There were incidents recorded of one person threatening to throw themselves over the bannister and tie a dressing gown cord around their neck. There was no ligature cutter within the home. We asked the provider to purchase one immediately. One person refused to have their incontinence pad changed which staff 'assumed was wet.' This resulted in a two person escort to assist the person to change their pad. There was no mental capacity assessment stating that the person did not have the capacity to make this choice for himself. Some BOCs stated that physical intervention was used but this was not recorded in the physical intervention book. One BOC stated that a person had threatened to harm themselves. A risk assessment stated that further observation should be

Is the service safe?

carried out in this case. There was no evidence that further observations had been carried out following the incident. A BOC recorded an incident where one person had removed a t-shirt from another person whilst they were wearing it. The person's positive behavioural support plan stated that the person had a behaviour of taking things from others but not physically off their person.

The use of restrictions within the home, and disproportionate use of restraint was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safeguarding service users from abuse and improper treatment.

There was a recruitment policy in place. Disclosure and Barring (DBS) checks were carried out before anyone could be recruited. These checks identify if prospective staff had a criminal record or were barred from working with people at risk. Potential staff had to provide two references and a full employment history, to ensure they were suitable to work within the service. However, we found that full employment histories had not been obtained for all staff. We were told that questions about employment history would have been asked at interview; however there were no interview notes included in the file. This meant that the provider could not be assured that those people were suitable employees as they had not obtained a full employment history prior to recruitment.

The lack of a complete employment history was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Fit and proper persons employed.

There were enough staff on duty to meet people's needs. The assistant area director explained how staffing was based on a combination of needs assessments and historical staffing ratios. This meant that it varied between four and five members of staff on a day shift and two members of staff were on a night shift. The provider had a maximum and minimum staffing level identified for each home. If one home was below the minimum staffing level and another home above the minimum staffing level staff would be transferred between homes to cover shifts. Bank staff were available to be called in and an on call system was maintained, meaning that management could be called in when on call to cover emergencies. The rosters reflected the staffing mix described. Observation showed that these were sufficient staffing levels to meet people's needs.

Staff had received safeguarding training and were able to describe sources and signs of abuse and potential harm. They also knew how to report abuse. Staff were aware of how to protect people from abuse. Cards were handed out to staff to remind them how to report anything they see of concern. Staff said they would feel able to whistle-blow, if necessary, without fear of reprisal. Safeguarding training was available for people entitled 'Keeping me safe from abuse.' The training was led by people who use services. Two people from Fountain View had completed this training.

Medicines were administered safely by staff who had been trained to do so. Staff had received medication training and had their competency to administer medicines had been checked. We reviewed records in relation to medicines. Medication Administration Records (MAR) were kept for each person. These were all signed appropriately with no gaps. Medicine stock levels were checked on a weekly basis and a medication audit had been carried out in March 2015.

Medicines were stored safely in a locked cabinet. An air conditioning unit was in the room to ensure medicines were kept in at a safe temperature and the temperature was monitored. Each person had individual records kept in relation to their medicines. These included a photograph, a diagnosis, what medicines they take and guidelines for medicines which needed to be taken 'as required.' Records showed how the person would indicate they were in pain. One person signed to say they had taken their own medicines. Current medicines were listed for each person in conjunction with relevant medicine information leaflets. A selection of medicines from a cabinet were checked and all were within date and had the date they were opened recorded.

Requires improvement

Is the service effective?

Our findings

Relatives did not always think that their family member's needs were being met. One relative said "He wants to be more independent but he's not being listened to. He knows there is another world out there." One person told us that they had been allocated a member of staff as a keyworker, who they didn't get on with. He said "I just didn't get asked." We asked the service to review their allocation of key workers.

People were asked for consent before care and support was provided. Staff told us they asked for consent before providing personal care and would do this in a way which people understood. The one person we spoke with told us that staff asked him for consent. However, records in relation to consent were confusing and inconsistent with what was known about people. Where people lacked capacity to make specific decisions, the provider should have acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. We found that although staff had received training in the MCA and were able describe the principles, the principles of the MCA were not being followed within the home. One person had signed to consent to an influenza vaccination, but there was no documented conversation regarding his understanding of the procedure and his ability to consent. The person did not have verbal communication skills and it was not clear that he understood and consented to the procedure. There was a statement in one person's care plan which said they didn't have capacity, but this did not state that it was in relation to a specific decision as required by the MCA.

One person had a best interest decision recorded in his care plan regarding the decision to live in the home. Best interest decisions are made once it has been determined that the person does not have the capacity to make the decision for themselves. There was no record of a mental capacity assessment regarding the decision to live in the home. Another person had a mental capacity assessment in respect of calling the police (as this was a known behaviour), where it was determined that he did have the capacity to understand this, however a Deprivation of Liberty Safeguards (DoLS) application had been made on their behalf. In order to deprive someone of their liberty, the provider must first determine whether the person has the capacity to understand and consent to the deprivation. There was no mental capacity assessment on file in relation to the DoLS.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that applications had been made without due regard to mental capacity. We also found there were deprivations within the home which were not the subject of DoLS applications such as locked doors, depriving people of freedom of movement.

The lack of appropriate mental capacity assessments leading to a lack of valid consent were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Need for consent.

Staff had received appropriate training to deliver the care and support for people living in the home. Records showed that training covered all essential areas such as medication, food hygiene and fire safety. There was also training about positive behaviour support and specialist training around intervention strategies. Staff had access to further development training. Some staff had completed vocational qualifications in health and social care and one member of staff had started an entry management and development program. Staff had regular supervision meetings and said they felt supported in their role. Training was available to people as well as staff. Courses included; keeping me safe from abuse, first aid and infection control. People using services were often involved in the running of the courses.

People were offered a choice of nutritional food. Menus were put together by staff based on people's known preferences. There was evidence that menus were discussed every so often during resident meetings but these were not held regularly. The menus were on a five week rolling rota. They were kept in written format in a file in the kitchen. People were not aware of the menu for the day, without having to ask, because the menus were not displayed on a noticeboard in an accessible way. This affected their involvement and choice in the way meals were planned and prepared. We saw that Makaton

Requires improvement

Is the service effective?

symbols, relating to food, were displayed in the kitchen but staff were not witnessed to be using them. Makaton is a language programme using signs and symbols which some people use to communicate. People were offered some choice of food at mealtimes, for example we observed one person chose pie instead of toad in the hole, which was on the menu, for that day. At lunchtime people were offered sandwiches and were able to choose their filling. People chose their own flavour of crisps, however no fruit was offered.

We observed lunch which was a relaxed and calm. People supported each other by pouring drinks and fetching different flavours of crisps to choose from. Staff told us that drinks and snacks were available whenever people asked for them, although there was a recorded incident when one person was refused chocolate. People were unable to help themselves to drinks and snacks as the kitchen was kept locked. However, apart from a recorded incident when chocolate was declined, there was no evidence that people were not given snacks whenever they asked.

Health professionals were appropriately involved in people's care. Records showed that people's health needs were met. One person received monthly health checks. Comprehensive health logs were kept within people's care plans, including appointments such as dental appointments. Psychologists were involved in people's care.

Requires improvement

Is the service caring?

Our findings

Relatives told us they were very happy with the care their family member received at Fountain View. They felt that staff understood their relative and provided comfort if needed. One person said "(a particular member of staff) knows me well."

Staff were supportive and caring and treated people with high regard. We observed people receiving support in communal areas within the home. Staff knew how to meet the needs of people and used some unstructured time to enjoy calming activities with people, such as doing puzzles. A member of staff from another service was working at the home on the day of the inspection but still understood people's needs. They made sure they addressed one man with complex communication issues when he was asking questions, as directed in his care plan. However, one member of staff continually ignored the questions, even though the person's communication plan stated that they had a need to ask constant questions until they understood. Staff used redirection to a pleasurable activity, according to his care plan, to calm him. One man had a habit of getting up, having breakfast and then going back to bed. Staff respected this. Staff showed that they understood people well, describing individuals progress at the service.

Two people were known to have girlfriends. Both talked about their girlfriends constantly showing how important the relationship was to them. Staff facilitated people to meet and spend time with their girlfriends. For example one person's girlfriend came to visit him during the inspection. We observed that the visit was accompanied by staff at all times. There was no care plan around staff facilitating the development of a meaningful relationship with his girlfriend or to support the expression of sexuality. The person's care plan stated that having a girlfriend was not important to him although this was clearly not the case. One man's care plan stated that he had a boyfriend but there were no plans as to how he was to be supported to pursue this relationship. Another man went to the cinema with his girlfriend but again there were no plans around this and no evidence of capacity in relation to consent.

People were encouraged to make decisions about their care and these were evident on a daily basis with people choosing when they got up, what they ate and what they did. They were involved in decisions about their medicines and had signed their medicine support plans. One person signed to say he had taken his medicines.

People were valued and respected by the provider. A provider wide service user committee had been set up involving people from different homes. One person from Fountain View attended the Committee. The purpose of the committee was to obtain people's input in respect of provider wide decisions such as social events, training and catering. Minutes showed that there had been discussion around an annual event called 'Choice got talent', which was an event celebrating people's talents. There was also a party planning committee which was attended by a person from Fountain View, encouraging involvement from people living in homes in the local area. People's talents were celebrated in other ways. For example, a directory called 'The People's First Choice Directory' had been developed. The directory included people with special skills which could be called upon by any of the homes owned by the provider. These skills included cleaning, gardening, washing cars, plastering and painting and knitting. People with specialist knowledge were also used to train other people for example in autism. People felt important and valued.

The atmosphere in the home was caring. We observed people were supported in a positive, caring way. Staff communicated well with people and role modelled behaviour reinforcing support recorded in support plans. Staff were seen laughing and joking with people in a positive way. People were seen to be looking after each other as if they were a family. People who were more able looked after those who were less able.

People's views about their care were sought through regular one to one meetings with their keyworker. Most people had these monthly, one person had weekly support meetings. Advocacy was available to people to help them express their views and two people had been assigned advocates to help them make decisions about their care. Advocacy services help people to be involved in decisions about their lives, explore choices and options and speak out about issues that matter to them.

Privacy and dignity was respected. We observed staff knocking on people's doors before they entered. One person told us he had a key to his room and could have private time in his room if he chose.

Requires improvement

Is the service caring?

One person told us he would like to be more independent. He said he would like to live in a supported living service and be able to visit his girlfriend whenever he wanted. A relative said that the person had been asking for some time to have increased independence and they were unsure why this had not been progressed. We asked the service to look into how the person could be supported to live more independently.

Requires improvement

Is the service responsive?

Our findings

Relatives told us they were pleased with the way staff had responded to their family member's needs. One relative said "I'm very pleased they have been able to bring him on as well as they have."

Some support plans were well written clearly demonstrating how they met people's needs. However, others were less well written, were sparse in content, included out of date and incorrect information. For example, some care plans used the wrong gender. Each person had records which included three different types of care planning. There was a care plan describing how to care for and support the person, a current folder which included daily observations and a 'Living the life' folder which included information about aspirations and goal setting. For one person his 'Living the life' folder lacked information. There was nothing in the section 'Is there anything (the person) would like to do for himself or learn to do?' the person was male but the file constantly refers to 'she' indicating the contents may have been copied and pasted from another person's file. In the section entitled 'Having fun' it just says 'being happy' giving no indication how the person liked to have fun or what made them happy. Another male person's file also constantly referred to 'her', the goals recorded were very limited including things like preparing a meal and cleaning. There were no person centred future aspirations which could be worked towards, for example the person told us they would like to move back to Blackpool. It was not clear what level of learning disability the person had; a needs assessment said he had severe learning disabilities with autistic traits whilst his overview assessment stated he had moderate learning disabilities. His personal information sheet said he had a mild learning disability. It was not clear from the care plan what level of learning disability the person had.

One person's care plan stated he liked socialising, swimming and drama but these were not mentioned in the person's 'Living the life' file. One person's care plan said they were using a reward chart with stickers. However, we did not see this in use during the two days of the inspection. For another person the section of the care plan entitled 'my story' was completely blank. Although the support plans lacked information, staff demonstrated that they knew people and were able to meet their immediate presenting needs. However, there were not appropriate goals and aspirations for people and nothing that evidenced how people would be supported to aspire to these goals. This demonstrated 'old fashioned' care as opposed to a progressive approach which maximised people's independence.

The lack of appropriate record keeping in relation to people's individual needs was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance.

During the inspection we observed unstructured activities such as games and making puzzles. One person was involved in making cakes whilst another spent time with his girlfriend. One person went to the cinema with his girlfriend which he was very excited about. One person had a large collection of thimbles in his room and was also very interested in Southampton football club. Various nostalgia from the club were displayed in his room. Another person had a fish tank in his room which staff said was very calming for the person. People chose how they spent their time.

Relatives and people told us they knew how to complain. There were no formal written complaints. Staff meetings were not held often, with the last one being held in April 2015. This was due to the absence of the registered manager. One member of staff said they were able to discuss issues at staff meetings however another member of staff said they didn't really feel able to raise issues at this time. The service was in a state of flux as both the registered manager and the deputy manager had left. There was not a clear reporting line for staff to raise concerns at the time of the inspection. This meant that there was a risk that not all concerns would be raised appropriately.

A quality residents and relatives feedback questionnaire had been carried out in July 2014. Everyone said that that they enjoyed the activities they were doing, got to go out enough and had holidays they liked. Feedback from relatives was less positive and had not been immediately responded to although the assistant area director recorded some actions to be taken during our inspection.

Requires improvement

Is the service well-led?

Our findings

There was a positive culture in the home, even though there was no registered manager at the time of the inspection and the deputy had recently left at short notice. Staff did appear positive and were confident that a registered manager would be recruited to make improvements to the home. The assistance area director was highly respected. During this period of transition the provider had appointed an interim manager from another home. The interim manager was extremely knowledgeable about systems and processes and inspired confidence.

It was unclear whether the registered manager, who had recently left, understood his responsibilities regarding notifying the Care Quality Commission (CQC) about important events, especially in respect of safeguarding. Records showed that several incidents should have been reported to CQC as a potential safeguarding but were not. For example threats to self-harm, allegations of abuse against staff, behaviour which put other people using the service at risk and choking.

The failure to notify CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, in relation to notification of other incidents.

Incidents and accidents were not always appropriately recorded. Difficult incident analysis forms could not be found and there were incident reports and behavioural observation charts which were still to be filed and mixed up with other paperwork in the office. Difficult incident analysis forms were designed to analyse difficult incidents, such as those involving restraint, so that learning could be derived leading to better outcomes for people. It was not possible to say whether learning could be demonstrated from incidents due to this lack of evidence.

Core values for the provider were displayed on the wall and were also given to staff on small cards. These values included 'integrity', 'dignity and respect', excellence', trustworthy and reliable' and ' committed and passionate.' Staff were aware of the values and were observed to be demonstrating these values through their work.

Staff told us they were aware of their roles and responsibilities. Expected standards of behaviour were included in employment offer letters so staff were aware of the expected standards before they started working for the provider.

There were systems in place to enable the service to deliver high quality care. Audits included health and safety weekly checks which covered electrical items, trip hazards, flooring and window restrictors. Records showed the fire alarm was tested weekly and fire evacuations were practised regularly, the last being on 12 June 2015. An infection control audit had been carried out in June 2015 and appropriate actions had been taken in response to findings. Yearly expert audits were carried out. An expert audit was when a person from another home visited the service and wrote a report about their perspective of the service. The last one had been carried out in February 2015 and looked at choice, activities, level of support, friendliness. It also looked at what qualities they would like to see in staff such as good listener, approachable and sense of humour.

Checks were also carried out at provider level. A management monitoring report had been carried out in May 2015 by the assistant area director. The visit looked at the five questions asked by CQC. Some shortfalls had been identified which unfortunately had not been immediately responded to as the registered manager left shortly after the visit. The assistant area director assured us that actions were now being taken.

People were involved in shaping the future of the service, in particular people were involved in staff recruitment. This was important to people and they looked forward to it.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 How the regulation was not being met: The registered person did not act in accordance with the provisions of the Mental Capacity Act 2005. Regulation11 (1) (2) (3)

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 How the regulation was not being met: The registered person used controls or restraint that were not necessary or not a proportionate response to the risk of harm. Regulation 13 (1) (4) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not maintain securely an accurate, complete 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 How the regulation was not being met: The registered person had not obtained information specified in Schedule 3. Regulation 19 (1) (2) (3) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

How the regulation was not being met: The registered person did not notify without delay any abuse or allegation of abuse to a service user.

Regulation 18 (1) (2) (e)