Selborne Care Limited

Selborne House

Inspection report

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Date of inspection visit:
12 July 2017
13 July 2017

Date of publication:
26 September 2017

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Selborne House is a care home for up to fifteen people who have a learning disability. At the time of our inspection thirteen people were living at this home. The home is split into two areas, called Ascot and Beverley.

We last inspected this service on 28 November and 01 December 2016. We found that people were not consistently receiving a good or a safe service. We found the provider was not meeting all of the legal regulations, and we used our enforcement powers to ensure this situation improved. At this inspection, we identified that some improvements had occurred, however these had not been adequate to ensure that people all received a safe, quality service, or to achieve compliance with the legal requirements.

There was a registered manager in place at the time of our inspection. 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.

Changes had been made to the systems used to audit the safety and quality of the service however these were still not effective. They had failed to ensure that all of the improvements needed were acted upon. The leadership of the service had not ensured that people lived in a home with a positive, empowering culture. People did not always receive an individual service that was respectful and which upheld their dignity. Action that the registered manager and registered provider had told us they would take to improve the service and to comply with the requirements of the law had not all been completed within the timescales agreed. The home remained in breach of two regulations and they had not increased their rating from Requires Improvement. You can see what action we told the provider to take at the end of this report.

While this inspection identified that improvements had been made to people's safety, we found that people were not consistently provided with a safe service. Risks people faced had not all been effectively managed, and reports of incidents had not always been used to review and change the support people received. Effective plans to reduce the risks that people presented to themselves and to others had not all been managed well. We have made a recommendation that professional, published guidance on the use of physical interventions is obtained. The management of medicines had improved, and our inspection confirmed that people were receiving their medicines as prescribed. Recruitment practices had improved, and people were now supported by staff that had been subject to robust checks before starting work.

The formal systems in place to ensure that restrictions to people's liberty were identified, and the required applications made to the supervisory body were good. However the knowledge of staff providing direct care about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) would not ensure people would be supported consistently or safely. This was brought to the attention of the registered provider at our last inspection, and the necessary improvements had not occurred.

The culture of the home was not consistently enabling and did not promote people's independence or involvement. There were limited opportunities for people to pursue hobbies and activities that were of interest to them, and which would reduce the risks associated with social isolation. The care and support provided was not always respectful and did not always uphold people's dignity. This was brought to the attention of the registered provider at our last inspection, and the improvements required had not been undertaken.

People were supported to see a wide range of health professionals and to eat and drink adequate amounts to maintain good health. Not all care needs had been effectively planned.

People were supported to stay in touch with people who were important to them. Visitors were made welcome at the home.

There was a formal system in place to raise concerns. This had not been provided in a format accessible to people who had additional communication needs. Informal systems including individual talk time meetings and unit meetings had not been regularly held. However people we spoke with told us they had little confidence that their feedback impacted the service provided.

The systems in place to ensure the quality and safety of the service (Governance) were also ineffective. We are currently considering what further action we need to take.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The support provided, written assessments and systems in place were not all being used effectively when helping people stay safe and reduce the risks associated with their conditions and needs.

People were supported by adequate numbers of staff.

People were protected by safe recruitment practices.

Medicines were well managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always consulted with and staff did not ensure that care was always provided in a way that promoted their human rights.

Staff training had been provided, however this had not ensured staff had all the skills required to meet people's needs.

People were supported to access health care services to ensure their health and wellbeing was maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated in a way that respected their dignity and showed respect.

People were not always consulted about their care and lifestyle.

People were supported to maintain and practice their culture and religion.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to do things that they liked and the environment people lived in lacked opportunities for engagement and stimulation.

There was an established complaints procedure that people were familiar with and knew how to use. People lacked confidence that changes would occur as a result of their feedback.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Adequate, effective and timely action had not been taken to respond to issues brought to the registered providers and registered manager's attention at our last inspection.

The systems in place to assess and monitor the quality of the service had not always been effective at identifying shortfalls and had not been used to drive forward improvements.

The culture of the home was not always enabling or empowering to the people living there.

Selborne 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 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 comprehensive inspection took place on 12 and 13 July 2017 and was unannounced. On the first day the inspection was undertaken by one inspector, on the second day, by two inspectors, a specialist pharmacy inspector and an expert by experience. An expert by experience is a person with experience of using a service similar to one we are inspecting. As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information from notifications to help us determine the areas we wanted to focus our inspection on. The registered Provider also returned a Pre Inspection Questionnaire (PIR). This contains information about the service Selborne House offers, as well as information about how the service plans to develop in the next 12 months. This was completed and returned as required. We also requested feedback from the local authority that purchase this service and Healthwatch. [Healthwatch is an independent organisation that champions the needs of people that use health and social care services.]

We visited the home and met all thirteen people currently living at the home, we also spent time in communal areas observing how care was delivered. Some people living at the home were unable to speak with us due to their health conditions. To help us to understand the experience of people who could not talk with us, we used our Short Observational Framework for Inspection (SOFI). .

During our inspection we looked at parts of five people's care plans. We looked at the systems in place to check medicines were managed and administered safely. We looked at the recruitment records of three staff. We looked at the checks and audits undertaken by the registered manager and registered provider to ensure the service provided was meeting people's needs and the requirements of the law. We received feedback from three health professionals that support people living at the home, and three relatives. We spoke with four members of staff and the deputy manager, administrator and the registered provider. The registered provider produced some records and information after the inspection, as these could not be

located at the time of our inspection.

Requires Improvement

Is the service safe?

Our findings

Some people's health care needs and lifestyle choices placed them, other people they lived with and the staff that supported them at an increased risk of experiencing harm. We looked at how these risks were managed to ensure people were kept safe. Notifications that had been sent to the commission as required showed that incidents between people living at the home, and incidents of people causing harm to themselves and to property had occurred. We saw some incidents had occurred that should have resulted in a review of the risk assessment for the person. The reviews we saw had not always taken the incident into account. One person whose care we looked at in detail regularly harmed themselves. There was no analysis of this information to help determine any patterns or to help staff best direct activities and support when the person most needed it. There was very limited evidence of how learning had been extracted from incidents to improve staff knowledge and practice, to change the support provided or to take action to reduce the likelihood or frequency of a repeat event occurring. We did not find that people were being fully protected from risks and avoidable harm.

We looked in detail at the support given to one person with complex needs. The person was allocated a member of staff to support them at all times. We saw that on some occasions the member of staff physically guided the person by holding their arm, and using this without the support of words to stop and start the persons' movement, and to steer them around the home. This level of physical intervention was not detailed in the person's care plan, and did not reflect published good practice guidelines for people that require high levels of support. Some people required staff to physically hold (restrain) them at times when they were particularly anxious or unsettled. Staff we spoke with were aware of how to help people calm down, and ways they could reduce this type of physical intervention being required. Care plans we looked at reflected good practice and offered staff numerous alternatives to try before using a physical intervention. Records of restraints showed that staff had been given the opportunity to talk about and reflect on incidents after the event. Records we viewed showed that CCTV recordings of the incidents were viewed and some feedback given to people involved. The records about this feedback, and the impact this had on care planning and reviews of people's care had not been clearly documented, and we could not see the impact this had made on staff practice. The records maintained by the home about these interventions were not adequate to fulfil published good practice guidelines. It is also considered good practice that registered managers and providers undertake an annual audit of their use of physical interventions so that both the registered person's and monitoring organisations can review the type and frequency of physical interventions used. This had not been undertaken.

We recommend that the registered manager and registered provider refer to published professional good practice guidelines on the use of Physical Interventions.

We looked at the care for a person with diabetes. Staff were regularly undertaking finger prick blood tests on the person. These are invasive and can be unpleasant. Staff we spoke with and care plans we viewed did not show the expected blood glucose range for the person, or what action to take if this was unusually high or low. The lack of this information meant the blood tests held little value, and staff were unclear what they were testing for. The process in place would not ensure that the risks associated with diabetes and unstable

blood sugar levels would be effectively managed.

Throughout our inspection we saw the majority of people looking relaxed. The atmosphere within the home was mainly calm. Feedback from people included, "I do mostly feel safe living here. Sometimes when other people are up and down, I don't feel safe," "It's a nice place," and another person told us, "Staff can be rough when they restrain you." We explored this with the management team, who were able to provide some assurance about this. Staff we spoke with explained to us how the care and support they provided focussed around people's needs and keeping them safe. Staff we spoke with were aware of different types of abuse and could confidently describe how they would report any concerns they had. Staff were able to describe the pro-active ways they worked with people to reduce the likelihood of incident occurring and people becoming distressed.

We explored with staff the action they would take in event of an emergency. Staff we spoke with had some knowledge that would enable them to respond quickly in the event of a person choking for example. We explored other scenarios, including how staff would respond to a person who had harmed themselves. The explanation given by staff and the resources available in the first aid boxes we looked at would not enable the staff to respond effectively or safely to this type of emergency. People each had a personal evacuation plan. For some people these detailed their individual support needs in the event of an emergency. For other people these were generic and not specifically about the person. This lack of consistency increased the risk associated with responding to an emergency.

At our last inspection we identified concerns with the way people were receiving their medicines. We found this situation had improved. People were receiving their medicines as prescribed. We observed people being given their medicines by the staff. The staff explained to people what they were doing and gave them the time that they needed to take their medicines. We heard one member of staff saying, "Tell me when you are ready for your medicines," which demonstrated a person centred approach. One person we spoke with told us, "I have to take a lot of tablets. The staff know I like the big tablets first, and they always provide me with a drink." However another person told us, "If we don't get it [referring to medicines] we get anxious and upset. They do sometimes forget [to administer the medicines] when they are working." We looked in detail at the medicines and records for five people living in the home. We found no further evidence that medicines had been missed or given late. Accurate records were kept of medicines received into the home, given to people and disposed of.

Some people had been prescribed medicines on a 'when required' basis. Information was kept in the home to show staff how and when to administer these medicines, so that they were given in a clear and consistent way that met people's individual needs.

Medicines were being stored securely, and at the correct temperatures. Controlled drugs were stored and recorded correctly. The provider completed regular medication audit to check that people were getting their medicines correctly. When any issues were identified from the audit action plans were produced and we saw evidence that improvements had been made.

At the last inspection on 28 November and 01 December 2016, we asked the provider to take action to make improvements to the environment. This action had been completed. New systems had been developed to report any items that needed repair or replacement and we saw that repairs that could be dangerous if left or repairs that could have a negative impact on people had been attended too quickly.

During our inspection adequate numbers of staff were on duty to ensure that people's needs were met at the time each person preferred, and for some people to access the community each day. Agency staff had

been utilised when required to ensure adequate numbers of staff were always on duty. Staff we spoke with told us that this was not always the case and that there were not always enough staff. They also informed us that not all agency staff had experience of the home, which limited the amount they could usefully contribute. One member of staff told us, "There aren't always enough staff. We do our best to pull together to limit the impact on the people." We looked at staffing records that showed for the majority of times the right numbers of staff were on duty to meet the registered providers staffing assessment.

At the last inspection the registered provider was in breach of regulation 19 of the Health and Social Care Act 2008. We asked the provider to take action to make improvements to the recruitment of staff, and this action had been completed. Robust checks had been made before offering new staff a position within the home. Completing these checks helps to reduce some of the risks associated with recruiting staff to work in Adult Social Care.

Requires Improvement

Is the service effective?

Our findings

People were assisted by staff that had received training and who felt supported in their role. One member of staff we spoke with told us, "The way we do training is good. We learn the theory and then apply it in practice. We have a chance to meet on a Friday and talk about how it is working." The inspection identified that although training had been provided it had not equipped staff with current, good practice knowledge about how to support and enable people with a learning disability. Our observations regarding staff use of physical intervention with one person and the failure to fully involve people in their care and lifestyle were examples of this.

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 who lived at the home had a range of communication needs. We observed that the people who could verbally respond to questions had many opportunities to make decisions and to consent to their care. One person we spoke with told us, "Every day I choose what I want to do." However the experience of people that required more support to communicate to consent and to make decisions was not as positive. We observed one person being physically led around the home by a member of staff. The person was not consulted or informed about the direction they wished to move in, but was physically 'steered' without consultation. This support was not consistent with the principles of the Mental Capacity Act.

We were shown a folder containing pictures of some forms of transport, that we were informed some people could use to help communicate how they wished to travel. We also observed a specialist communication tool. However the symbols used on this tool were out of date, and did not reflect current food packaging. The tool was not used throughout our visit. A member of staff we spoke with told us that one of the improvements that had occurred since our last inspection was that staff were better at asking people how they would like to be supported. The staff member was unable to give any examples of this in their practice. People had been supported to attend appointments with primary healthcare professionals such as the GP and dentist when this was necessary. However it was not evident that more specialist advice had always been sought for people. This included support for people that required help with communication. People were not consistently given the support they required to communicate, make choices and consent Some care records we viewed we saw that relatives had consented on behalf of their family member. The staff we spoke with were not aware that this was not appropriate, or of the need to make Best Interest decisions, when people needed support or are unable to make decisions independently.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Systems were in place to ensure that applications would be made to the supervisory body, and to ensure these were applied for again before they expired.

Staff we spoke with were not able to confidently describe the impact the restrictions had on people's care or day to lives. The agreed restrictions, such as the front door being locked were in place, however staff were unsure what they would or could do if a person did leave the building for example.

We found that people's experience with food and drinks also varied. One person we spoke with who was able to make choices and participate in cooking told us, "The food, it's alright. I cook. I'm having bacon this morning, I'm doing it myself. I'm having curry later. We go to the shop ourselves to get the food." For people who found communicating their wishes more difficult we found that the opportunities were more limited. Specialist resources to help people make choices were not available, and the methods staff described to help people make choices were inconsistent with their needs. However, another person whose care we looked at in detail had specific needs in relation to eating and drinking. Staff had involved the necessary professionals to undertake assessments and to develop guidelines that would ensure the person could eat and drink as safely as possible. During our inspection we saw the person receive support that was in line with these guidelines.

People had mostly been supported to maintain good health, and to access the healthcare services relevant to them. Changes in people's healthcare needs had been noted and support and advice had been sought from the relevant professionals when required. Health professionals we spoke with told us that people were supported to attend appointments when necessary and confirmed that staff co-operated with recommendations they made. One person whose care we looked at in detail had been weighed and found to be obese. We saw that weight records showed the person continued to gain weight, and no plan to help the person make healthy lifestyle choices had been developed. When brought to the attention of the deputy manager we were assured these matters would be reviewed with health professionals. Staff had developed hospital passports for people which would help people receive continuity of care in the event that they required treatment in hospital.

Staff confirmed they had received an induction that equipped them to support people. One member of staff told us, "I did two weeks training, watched DVD's, did some buddy and shadow shifts. I'm still learning and getting support. If I ask any of the more experienced staff they will help me." [Shadowing or buddy shifts involve working alongside more experienced staff members]. The organisation had ensured that the Care Certificate was available for any new staff starters that required it. The Care Certificate is a nationally approved set of induction standards that ensure staff have the knowledge they need to provide good, safe care. Existing staff were also working through this as a way to increase and refresh their knowledge.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we asked the provider to take action to make improvements to make sure the care offered was person centred and was delivered in partnership with people. We identified that the care and support offered on Beverley Unit was mainly task focussed. We reported that the staff did not always communicate effectively with people to express their views and make decisions about their care. At this inspection we found that the provider's action plan had not been effective and adequate improvements in this area had not occurred. The staff we spoke with and observed all worked in ways that appeared well meaning and kind, but which were not always appropriate and which did not always uphold people's dignity or show respect. Some of the care we observed was task orientated, and we saw staff missed numerous opportunities to interact and relate with people. Some of the people on Beverley unit had healthcare needs that meant they were unable to describe their experience of this and how it made them feel.

Some of the people we met were not able to explain their needs and wishes verbally. The staff we spoke with told us that they sometimes used pictures or symbols to help people make decisions, however we only observed limited use of one communication aid that helped people chose the transport they wished to use. Staff described some of the ways they helped people choose foods. The methods described were not all consistent with the communication style and needs of the people we met. While it was positive that people were offered the opportunities to be involved in these choices, it was not evident that the methods used would always be suitable or appropriate to the people living at Selbourne House.

While many of our observations of the support people received were good, we did observe and hear some interactions between staff and people that could have involved the person more, or where staff could have informed the person about the action they were about to undertake that involved them. This included staff entering the room, taking the person out the room, or sitting down beside people without any greeting or explanation. On one occasion a member of staff sat beside a person who was sleeping and reclined on a sofa. The member of staff sat very close to the person's head with no introduction, or verbal warning to the person to expect this.

We also heard and observed some interactions when people were not related to in an age appropriate way. When telling us about people's needs some staff spoke in front of the person they were telling us about. When describing people's behaviour some staff told us that people had, "Been good." One woman was repeatedly described as a, "Good girl." Our observations found that people's dignity was not always upheld. The staff actions did not appear to cause the people on Beverley unit any distress; however some of the people on Ascot unit described how this made them feel. Their comments included, "The way staff are with me sometimes makes me angry." Records we reviewed showed that similar observations had been made by a visiting professional. They reported that the interactions between staff and people had negatively impacted on the person's willingness and motivation to work on developing further independent living skills with the staff.

We observed that people were offered all their drinks, including hot drinks in plastic beakers. These had no

handles, and were not reflective of the crockery or mugs other adults would drink from. Efforts had not been made to source suitable, safe crockery for people that was reflective of both their needs and age. We observed people going out from the home into the community. People were not consistently prompted to adjust their clothes to ensure they maintained their dignity. We spoke about our observations with the registered provider who agreed this culture needed to be challenged and improved. Similar feedback was shared with the registered provider and registered manager after our last inspection, therefore we could see that there had been no improvement.

People were not receiving a service that was personalised for them. Staff lacked the specialist knowledge to engage and consult with people who had complex communication needs. People were not consistently receiving care and support that was appropriate, that met their needs, and that reflected their preferences. We found that that the registered provider and registered manager remain in breach of regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Throughout our visit we saw people were mainly supported by staff that they had got to know well. One of the relatives we spoke with described increased continuity of staff as a positive change within the home in the past six months. Feedback from people on Ascot unit was mixed, but included, "We've got some new staff, they're better. It's getting better and we can talk more, the new staff help more and show more interest", and "I really like the staff." People on Beverley unit looked relaxed with the staff who were supporting them, and the atmosphere in the unit was calm. A relative we spoke with told us, "It is good care."

Staff were aware of the individual wishes of each person, relating to how they expressed their culture, religion and gender. People had been supported to attend places of worship and to follow dietary requirements relating to their faith and culture. One person we spoke with told us how they had enjoyed celebrating Christmas at the home. They told us, "At Christmas we had turkey, a big table laid out, presents, food all on the table, it was great."

People's relatives and friends reported that they were made to feel welcome at the home, and that there were no restrictions on their visiting. People were supported to make contact using the phone when they wished. This helped people to maintain contact with people who were important to them.

Requires Improvement

Is the service responsive?

Our findings

People had some opportunity to be involved in developing and reviewing their care plans. One person we spoke with told us, "Sometimes we get involved in writing our plan, sometimes we get stressed about them and leave it." Another person told us, "Yes, I have reviews, it's with the staff and I have one soon." Our observations and people's care records showed that each person had been provided with the personal care that they required, however this was not always planned or delivered in a way that was specific to each person. Adjustments had not been made, staff had not been trained and resources were not available that would consistently support and enable people to make decisions about their own care and lifestyle.

There were no set times for getting up or going to bed, and meals and drinks were served flexibly throughout the day. For people living on Ascot unit we saw this was driven by the individual, and was evidence that the person carried out their personal routine as they wished. One member of staff we spoke with told us, "There are no set support times, we just try and be ready when the person is ready." However on Beverley unit we observed people usually all ate at the same time, and some long gaps were noted between the meals. We could not establish how the times for meals, drinks and snacks had been established, or if this was the choice of every person.

Activities and opportunities for day trips to places of interest had been provided for people and people we spoke with had enjoyed these. However we could not always see how these opportunities had been discussed, or how the people had been chosen to participate in them. Our observations and the records we looked at showed that some people had frequent opportunities, while other people had far fewer. There was no clear objective for the activities, or evidence about how these activities fitted with people's preferences or life goals. On Beverley unit we observed the same people on both days of our inspection sitting in the communal area of the home with very little to do. Although people expressed no dissatisfaction with this arrangement we saw that the activities available were limited to colouring, listening to music and self-stimulation. We asked about the opportunities for one person who appeared disengaged. The member of staff told us that their lifestyle was very similar every day. A relative we spoke with told us, "I always go and visit unannounced. It's rare that [name of person] is out. They go out infrequently." People had some opportunities to develop skills related to independent living such as making simple meals and drinks, and helping staff with laundry.

There was a process in place for people to raise formal complaints, however this had not been adjusted to support people with additional communication needs to use it. Notes of meetings held with people identified that concerns and suggestions had sometimes been made. The notes of meetings did not always show how these were taken forward or acted upon. No complaints had been received in the past 12 months.

Notes of meetings held with people identified that concerns and suggestions had sometimes been made. The notes of meetings did not always show how these were taken forward or acted upon. No complaints had been received in the past 12 months.

We asked people how they had opportunity to participate in the development of the service, and to find out about changes. People informed us that there were sometimes meetings for people to attend, or individual talk times with staff. The records we viewed showed these had not occurred as frequently as planned. Some people told us they had lost confidence in the meetings as changes did not always occur and feedback was not always given about the suggestions they made. Records we viewed showed this had on some occasions been true, although on other occasions people's suggestions had influenced change and development. We were informed that people had been consulted with and involved in choosing the colour and décor of the communal areas of the home, and in choosing door art for their bedroom doors, that reflected their interests and personal taste. People described having lost confidence in the consultation process as they had not seen it consistently working effectively regards matters they had raised. The systems in place to engage and consult with people were not always suitable or attractive for the people living at Selborne House.

Requires Improvement

Is the service well-led?

Our findings

We last inspected this service on November 30 and December 01 2016. During that inspection we found that the systems to monitor the quality and safety of the home [Governance] had not been effective. The impact of this on people had been significant. People could not be certain they would consistently receive a safe or well managed service. We issued a warning notice. This is one of our enforcement powers. The warning notice required the registered provider to take urgent action to improve the governance of the home. During this inspection we tested the changes and improvements the registered provider had made. We found that some improvements had been planned and made however these had not been adequate or undertaken promptly to ensure that the service people received was always safe, of a good quality and continuously improving.

The registered manager and the registered provider had developed new audits and checks since our last inspection. In some areas of the service these had worked well, and we found the premises were now better maintained, that robust recruitment checks had been made and that medicines were being managed safely. Other audits we looked at including those for care planning had been effective at identifying that action was required but they had not resulted in changes or improvement taking place. The work required had not been allocated to specific people. No follow up checks had been made to ensure that the changes required had been actioned, or that the new style of working had become embedded into practice. Some of the environmental audits had recorded repairs being carried forward for up to eight weeks without being resolved. While these did not have a significant impact on people's safety our discussions with the deputy manager, nominated individual and review of the records failed to provide a reason why this would be the case. There was no monitoring or overview of these longer term repairs. Members of the management team were unsure why repairs had not already taken place, or when they would be achieved. The audits we viewed were not all dated or signed, and it was not possible to establish how long ago they had been completed or by whom. We checked and found that changes and improvements that the auditor (a member of staff working on behalf of the registered provider or registered manager) had identified as being required had not been made. These findings did not provide evidence that there was effective management oversight or that timely action was being taken to continuously monitor and improve the service.

The checks and audits undertaken had not provided a good overview of the operation of the home, or picked up on staff practice or quality of life experiences for people living at the home. Throughout our inspection we identified that the management of the home was open to feedback, however the management team were acting responsively and did not have an effective development plan, or clear vision for the progression of the service.

At our last inspection we found the registered manager and registered provider had breached three parts of the law that they are required to comply with. In response to these breaches the registered provider and registered manager had developed action plans. One of the three action plans had been effective at driving forward improvement, but the other two had not. Two of the action plans had not been kept under review, or revisited on a regular basis to ensure they were being effective. The deputy manager of the service, who was in day to day control of the home at the time of our inspection, was not familiar with the action plans or

their content. This did not provide evidence that they were active, working documents, being used to drive forward improvements.

The improvements required by us to ensure people received a person centred service and to comply with regulation nine of the Health and Social Care Act 2008 had not been made within the timescales the registered provider and registered manager had set for themselves. The improvements required to meet the requirements of the warning notice had not been made within the timescales set by the commission. The service was rated as Requires Improvement at our last inspection. The action taken by the registered provider and manager had not been adequate to see this rating improve.

The systems and processes in place to assess, monitor and improve the quality and safety of the services provided had not effective. Risks relating to the health, safety and welfare of people using the service had not all been assessed and monitored and action had not always been taken to mitigate against these risks. We found that the registered manager and registered provider remained in breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager also has day to day responsibility for the running of another of this provider's services. The registered manager was on planned leave and was not able to be present during this inspection. Staff we spoke with told us that they had a reasonable rapport with the management team. Comments from staff included, "The management team is okay, we see the registered manager sometimes, the deputy manager is usually here, we get most of our direction from the team leaders."

People living at Selborne House told us they mostly liked the service and described ways they had benefitted from the service they had received at the home. Staff we spoke with reported positively about the management of the home. Comments from one member of staff was, "The managers are okay, approachable, and fair." Registered providers are required to prominently display their most recent inspection rating within the home and on their website. This was on display. This demonstrates an awareness of this requirement, and a commitment to openness and transparency.

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 9 HSCA RA Regulations 2014 Person-centred care People were not consistently receiving care and support that was appropriate, that met their needs, and that reflected their preferences.