Principle Care Limited

Touchwood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 and 14 June and was announced.

Touchwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Touchwood is registered to provide accommodation and care for up to five people with learning disabilities or autistic spectrum disorder. At the time of our inspection three people were living at the home. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had not had a registered manager in place since 14 October 2016. This is a requirement of the provider's registration. 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. We served a fixed penalty notice due to this failure to comply with this condition of registration.

Robust governance and quality monitoring systems were not established or embedded within the service. This meant that some areas for improvement were not always identified, lessons were not always learnt and actions had not been put in place to address them.

Risks were not monitored adequately, including behaviours that challenge by the provider. Incidents were not fully assessed to assess and mitigate risks. Records of incidents were also not recorded and stored adequately to allow effective monitoring.

We had not received any notifications since July 2017 and we identified concerns during the inspection that we should have been notified about. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. This was a breach of the services registration requirements.

Staff were able to tell us how they would report and recognise signs of abuse and had received training in safeguarding. Professionals, staff and relatives told us they had no concerns relating to safeguarding.

Medicines were managed safely, securely stored, correctly recorded and only administered by staff that were trained and assessed as competent to give medicines. However, improvements were required to implement checks on the temperature of the medicine storage room, maintenance of the medicine fridge

and how audits were undertaken.

There were systems in place to carry out checks on the building to ensure it was safe. Staff understood their responsibilities for infection control.

Relatives raised concerns with us there were not enough staff at times in the evening to meet people's needs. Concerns were shared with us that when only one member of staff worked in the evening staff could not support people individually to go into the community or spend one to one time with them. We made a recommendation that the provider reviews staffing levels in the evening.

Improvements were required to how all staff were supported to carry out their roles and attend specialist training. Improvements were required to how temporary staff were supported to understand the needs of people and to carry out their roles.

Staff told us they had not received regular supervisions. However, staff told us they felt supported by the manager and other colleagues to carry out their role. We made a recommendation about the supervision and appraisal of staff.

Staff were aware of the Mental Capacity Act and training records showed that they had received training in this. Assessments of capacity and best interest decisions were not all recorded. We made a recommendation about the assessment of people's capacity to make specific decisions and arrangements for best interests.

Applications had been made where required to authorise people's Deprivation of Liberty and conditions set out in one person's Deprivation of Liberty Safeguards were met.

People and staff told us that the food was good. We reviewed the menu which showed that people were offered a variety of healthy meals of their choice.

People were supported to access healthcare appointments as and when required and staff followed professional's advice when supporting people with on-going care needs. For example, one person was supported to see their GP following advice from a chiropodist. Records we reviewed showed that people had recently seen the GP, district nurses and a chiropodist.

People and relatives told us that staff were caring. We observed positive interactions between staff, managers and people. This showed us that people felt comfortable with the staff supporting them.

Staff treated people in a dignified and respectful way. Regular staff had a good understanding of people's interests and their preferred routines.

Staff responded to the changes in people's needs but not all care plans reflected people's current needs.

People were encouraged to feedback. House meetings took place weekly which gave people an opportunity to give their feedback about what they enjoyed doing.

There was not a system in place for recording complaints within the service. People's relatives told us they had raised some concerns but they had not always been responded to.

Improvements were required to how the service was managed to ensure that staff were clear of their

responsibilities when the manager was not based within the service or on leave.

The service worked in partnership with other agencies.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach under Health and Social Care Act 2008 (Registration) Regulations 2009.

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 always safe.

Processes were not in place to make sure that incident reports were reviewed and analysed or to ensure lessons were learnt when things went wrong.

Improvements were required to how identified risks were monitored to ensure there was a consistent approach to how risks were mitigated and risk management plans were updated.

Staff and some relatives raised concerns about staffing levels in the home in the evening and the impact on person centred care.

Staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People's relatives and staff told us they felt people were safe living at Touchwood.

Medicines were managed safely but some improvements were required to the monitoring of the temperature of the medicine storage areas.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff worked within the principles of the Mental Capacity Act 2005 but improvements were required to how assessments were completed for specific decisions and arrangements for best interest decisions.

Conditions set out in peoples authorised Deprivation of Liberty Safeguards were met.

People's needs and choices were assessed but care plans required updating.

Staff received training to give them the skills they needed to carry out their roles but some improvements were required to ensure all staff were supported to carry out their roles.

People were supported to eat and drink enough and dietary needs were met.

The service worked within and across other healthcare services to deliver effective care.

People were able to access different areas of the home freely.

People were supported to access health care services and other professionals as and when required.

Is the service caring?

Good

The service was caring.

People were supported by staff that treated them with kindness, respect and compassion.

Staff had a good understanding of the people they cared for and were actively supported and independence was promoted.

People were supported by staff who respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A complaints procedure was in place but relatives told us their concerns were not always responded to by the management team. Records of complaints were not maintained at the service.

The service did not meet the requirements of the Accessible Information Standards.

People were supported by staff who used person centred approaches to deliver the care and support they required. Improvements were required to how people's changing needs were assessed and recorded.

People were supported by staff that recognised and responded to their changing needs.

People were supported to access the community and take part in activities within the home.

Resident meetings took place which provided an opportunity for people to feedback and be involved in changes.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had not been a registered manager in post since 14 October 2016

Governance and quality monitoring systems were not established or embedded within the service. This meant areas of improvement were not always identified.

Improvements were required to the systems and records relating to service users and the management of the service.

The management had not notified us of events which affected the running of the service and the care people received.

Improvements were required to how the service was managed and arrangements for accountability and delegation of management tasks.

Staff received feedback from the management team and felt included and recognised for their work.

Improvements were required to the communication with relatives and their involvement in the review of their relatives' care.

Touchwood

Detailed findings

Background to this inspection

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

This inspection site visit took place on 12 and 14 June and was announced. We gave the service 24 hours' notice of the inspection visit because it was small and we needed to be sure that people would be in. The inspection was carried out by one inspector.

Before the inspection we reviewed all the information we held about the service. This included any notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted a local authority quality assurance team to obtain their views about the service prior to our inspection.

We did not request a Provider Information Return for this service. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection.

We spoke with two people who used the service, two relatives and met with four staff. We had telephone conversations with a quality improvement officer, and two social care professionals.

We spoke with the nominated individual, quality assurance manager, operations director, quality assurance director, estates manager. We reviewed three people's care files, and looked at a range of records about people's care, medicine administration, staff recruitment and records relating to the management of the service. We observed staff interactions with people.

We asked the nominated individual to send us information after the visit. This included training and recruitment records, quality survey analysis from 2017 and the action plan from audits carried out by the quality assurance manager.

Requires Improvement

Is the service safe?

Our findings

Safe systems were not in place to ensure that incident reports were recorded and stored adequately to allow effective monitoring. Not all incidents were reviewed and analysed to identify changes to how care was planned and delivered. Not all incidents had been shared with the corporate management team. For example, the operations director and quality manager had not been made aware of all recent incidents. This meant that there was not an effective oversight of incidents to identify possible trends and ensure appropriate action was taken. One member of staff told us, "We need a system to be put in place for incident reports. They are left on the side and can go missing". We were told that this was because the previous electronic version was now not being used by the organisation and they had reverted to paper copies. This meant there was a risk that people could receive inappropriate or unsafe care as incidents were not reviewed adequately. The quality assurance director told us told us the policy would be reviewed and a system put in place as a matter of priority.

Improvements were required to how risks were managed and risk management plans needed to be reviewed and updated. Some people presented behaviour which challenged. Not all risk assessments and positive behaviour plans had been reviewed following incidents to ensure that the plan of care reflected people's current needs. However, staff that worked regularly at the service were aware of risks people faced and how to manage these risks. For example, staff were clear how they supported people in the community to keep them safe and how they supported someone with their mobility. One relative told us they were concerned about the protocols in place when one member of staff was lone working in the evening in the service. One member of staff raised concern that there was a risk that not all temporary staff who lone worked at times would be aware of the best approach to support some people with behaviour that challenge others. This meant that people were at risk of receiving unsafe care as the provider had not ensured that risk assessments and risk management plans had been updated to reflect people's current needs .

Staff and relatives told us they had no concerns relating to how people were cared for. One person communicated that they did not have any concerns. One relative told us, "I feel [the person's name] is safe living there [Touchwood]. Another relative us they had no concerns. Staff were able to tell us how they would recognise signs of abuse and who they would report these concerns to. These included contacts with the local authority. There was a safeguarding policy in place and staff had received safeguarding training. Actions had been taken in response to an incident between two people that lived in the service and actions taken to safeguard both residents. One social care professional told us they had been informed of concerns in the past involving a former resident. They also told us the service had been proactive at managing these concerns. There were no current safeguarding concerns. A relative told us, "[Person's name] is safe living there [Touchwood]".

Improvements were required to ensure information about the support people required with medicines was updated and was kept confidentially. Medicine information displayed on the wall in the medicine room about how to support people with their medicine had not been updated. One member of staff confirmed that the approach to how one person was supported with their medicine had been updated in the person's

medicine administration records and the information displayed on the wall was no longer current.

Medicines were stored securely and keys were held by authorised staff. Medicines were only administered by trained staff who had been assessed as competent. Improvements were required to implement checks of the temperature of the medicine storage room and how audits were undertaken. There was one medicine audit completed in the service and the audit had not identified that information displayed on the wall was out of date and there were no temperature checks for the storage of medicine. Staff told us the fridge used for the storage of medicines was not working. The nominated individual told us they would arrange for this to be repaired or replaced. There were no prescribed medicines that required storage in a fridge at the time of the inspection.

Relatives raised concerns with us there were not enough staff at times to meet people's needs in the evening. The senior management team told us that two staff worked each evening. Two relatives told us there was regularly only one member of staff in the evening. One relative told us this meant staff at times could not support their relative to go out. We saw from rotas that two staff did not work each evening and this was confirmed by staff. Staff told us that they felt there were sufficient numbers of staff to deliver safe care when one member of staff worked alone in the evening. However, staff told us when staff worked alone this impacted what they could do to support people individually to meet their needs. One member of staff told us, "It would limit someone doing an activity or someone popping out to get milk". Another member of staff told us the manager had listened to staff concerns about staffing levels in the evening and the home manager was reviewing this. They told us, "The guys like two staff on until 11pm". They told us this allowed the staff team to respond to people's requests for one to one time and to support people more effectively. The provider was not able to update us at the time of the inspection about these concerns.

We recommend that the provider reviews their staffing levels in the home to ensure there are enough staff to meet people's needs.

Safe recruitment practices were followed. Recruitment checks included obtaining references from previous employers, checking people's eligibility to work in the UK and undertaking criminal record checks. These checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults.

Staff were clear on their responsibilities with regards to infection control. The home had equipment and cleaning schedules in place to clean the home effectively. All areas of the home were kept clean to minimise the risks of the spread of infection. There were hand washing facilities and staff had access to Personal Protective Equipment (PPE) such as gloves.

There were systems in place to carry out checks on the building to ensure it was safe. There were certificates to confirm it complied with gas, fire safety and electrical safety standards. Following a fire risk assessment of the building, the provider told us additional works were being completed to fit an additional smoke detector. Each person had a Personal Emergency Evacuation Plan (PEEP), which set out the specific requirements that each person had to ensure that they were safely evacuated from the service in the event of a fire. The provider told us they had also arranged for a building fire risk assessment to be carried out on 25 June 2018.

Requires Improvement

Is the service effective?

Our findings

Improvements were required to how all staff were supported to carry out their roles. The majority of staff told us they received training and support to carry out their roles. Comments from staff included, "I am up to date with my mandatory training", "I had safeguarding refresher training last month" and "I have had Maybo training (specialist training for supporting people with behaviours that challenge), that teaches you to know the signals or triggers in supporting people". However, one member of staff who had been in post for 10 months had not received training on supporting people with behaviours that challenge. We raised this with the nominated individual who told us they would action this. Two members of staff raised concerns with us about how temporary staff were supported to carry out their roles. The registered provider used temporary staff on a weekly basis due to staff shortages. One member of staff told us, "What worries me is that when agency comes in they have a brief handover" and "they don't understand the triggers". This meant that there was a risk of people receiving unsafe or inappropriate care as not all staff were supported to carry out their role.

Staff did not receive regular supervision or appraisals to ensure they had the support and competency to carry out their role unsupervised. Two staff told us they had not supervision with a manager for approximately a year and one member of staff said their last supervision was approximately 10 months ago. One member of staff told us, "Supervision needs to happen more often". We raised this with the provider who told us they would take actions to improve this. However, staff told us they felt supported by the home manager and the staff team worked well together to support each other. One member of staff told us the staff team regularly shared approaches of how they supported people so they had a consistent approach and to get the best outcome for the person. Another member of staff told us, "I feel supported and [the home manager] is always contactable by phone if they are not here".

We recommend that the provider considers good practice guidance to ensure all staff receive appropriate support, training, supervision and appraisals to carry out their roles.

There were systems in place to support new staff with completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. New staff were supported by experienced staff by shadowing shifts and their competency was assessed. A staff member said, "My medicine competency was checked before I started administering on my own".

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

Staff understood the principles of the MCA and how it applied to the people living at Touchwood. Staff told us when and who they would involve if a person lacked capacity. People's capacity and ability to consent to some aspects of their care had not been assessed on an issue specific basis. People's relatives told us they were involved in some decisions about their relative's care. However, one person's relatives raised concerns with us they had not been involved in a specific decision about their relative's care.

Where people were deemed to lack capacity to give consent, decisions were made in their best interest. This involved people with the authority to act on their behalf, family, staff familiar to them and social care professionals. However, this was not always recorded. Decisions had been made for people who lacked capacity regarding the care provided and being assisted with medicines. However, decisions taken were also not regularly reviewed to ensure they were still in the person's best interest and the least restrictive approach. The quality manager shared with us an action plan that highlighted that the service needed to complete the consent to care assessments by 10 April 2018; including mental capacity assessments and best interest decisions where applicable. This work was still outstanding. They told us action would be taken to address this.

We recommend that the provider considers good practice guidance to ensure that the service understands and meets the requirements set out in the Mental Capacity Act 2005.

Staff were clear where people had the mental capacity to make certain decisions, this would be respected. Throughout the inspection we observed consent being sought regularly for all activities such as where people wanted to spend their time, and what they wanted for their lunch. Staff were seen to respect people's choices.
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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person had an authorised DoLS in place and two people had an application pending assessment with their local authority. One person had conditions applied to DoLs, and these were being met.

Staff supported people to eat and drink sufficient amounts to meet their needs. People were supported to make choices about what food they wanted to eat. One person gave positive feedback about the meals provided. They showed us the menu and what they liked on the menu. People's nutritional needs and specific dietary needs were reviewed and regular checks maintained on their weight and advice sought and followed from people's GPs. Staff had completed food hygiene training.

Staff worked with outside organisations to help deliver effective care and support to people. Staff linked with health professionals in ways that supported individual needs and personalised outcomes. People were supported to attend health appointments to maintain their health and to seek medical advice where necessary. This included supporting access to GPs, and chiropodists. We observed that staff supported someone to attend an appointment with their GP. However, health action plans had not been completed in line with good practice to support people to identify what was important to them and to support people to stay healthy.

Improvements had been made to the furnishing of the home. New carpet had been fitted in the lounge and new furniture and television had been ordered for the communal lounge and garden furniture. Staff told us people had been involved with these decisions. One relative spoke very positively about these improvements and told us, "They are making the house look more homely". Work had also been undertaken in the garden to allow more of the garden to be accessed by people. One person showed us the new garden furniture and helped a member of staff to move it to the position in the garden they wanted it. People

moved freely around the home and some people chose to spend time in their rooms at times, watching sporting competitions on the TV, together in the lounge or having lunch in the garden. The nominated individual told us there were plans to redecorate the home and make further improvements.

Good

Is the service caring?

Our findings

People's relatives and one person who spoke to us spoke positively about staff and told us they were kind and caring. One person's relative told us, "The staff group are absolutely amazing. They are kind, caring, efficient and provide good care". Another person's relative told us, "The staff are very good, they work really hard". One person told us the staff were nice and they told us that one member of staff was their favourite. There was a positive atmosphere in the home and people appeared relaxed with the staff that supported them and other residents. We observed staff talking to people in a kind and respectful way and focusing on the person's routine, what was important to them and anticipating people's needs. People smiled and joked with staff. Staff were patient, attentive and spoke to people in a caring manner. One member of staff told us, "All staff treat the guys with respect".

People's privacy, dignity and independence were respected and promoted by staff. The staff team worked together to ensure that people's wishes were respected. Staff were aware when people liked to be alone and the importance of this for them to relax or calm down if they were distressed. Staff responded to people's request for company, respected when they wanted to be alone and their wishes. For example, one member of staff told us that one person preferred a male care worker to go out to an activity in the community with them. They told us the staff worked together to ensure this happened and at times they came in outside of a normal shift to enable this to happen. Rotas for these times supported this information. Another member of staff told us they supported one person to go shopping and promoted their independence. They told us, "I stand back and let [the person] do their shopping". People had been supported with their personal care needs and staff respected what people aspects of personal care people could do for themselves.

Bedrooms were personalised with people's belongings, such as furniture, photographs and personal belongings to help people to feel at home. A person told showed us their room and communicated to us they were happy with their room and had their belongings around them that were important to them. One person had to move temporarily due to a flood. The person' temporary room had been arranged with the person's belongings and maintenance work was being undertaken to allow the person to move back to their preferred room.

Staff demonstrated that they knew, understood and responded to each person's diverse needs in a caring and compassionate way. For example, one member of staff told us they had started taking one person a cup of coffee up to their bedroom in the morning as they did not sleep well at night to support them to get up. They spoke compassionately about this person and told us all of the staff team were following this approach. Other staff told us what support they provided to meet people's needs to support them to do things they enjoyed but to also respect the people they shared a house with. Staff spoke positively about the care provided by their colleagues.
People were supported to maintain contacts with friends and family. This included visits from and to relatives and friends and regular telephone calls. A person told us, "I sometimes choose to see my family. They can visit me too as and when they wish". During our inspection one person's relative had arrived to take them out for the day. A relative said, "There is no restrictions on visiting. I am always made to feel welcome here as are other family members".

People were encouraged to make decisions about their care, for example how they wanted to spend their time and to express their wishes. One person told us they had decided to go on the train home with a member of staff rather than travel back with other residents from an activity in the car. The member of staff told us this person had requested that they wanted to go to the high street rather than go straight home that day. The person's choice and decision how to spend their day was respected. We observed the member of staff promoting that choice to make a different choice than what was planned. Another member of staff told us they responded to signs that someone was becoming distressed by asking them if they would like to do something with a member of staff, such as going for a walk or watching TV.

Requires Improvement

Is the service responsive?

Our findings

Care plans had not been updated to ensure all staff were aware of people's current needs. This meant there was a risk that people could receive care that did not meet their needs. The quality manager told us people's care plans were currently being updated by the manager. This had been identified through an audit of the service on the 20 March 2018 to be completed by the 31 March 2018. Care plans were person centred but two people's care plans had not been updated and did not always detail people's current needs. One person's relative told us they had attended a review of their relative's care needs a couple of weeks prior to our inspection with the manager and social worker. They told us they felt confident that staff and the manager knew their relative's needs and they were kept informed.

The service did not fully meet the requirements of the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. There were not arrangements in place to assess and review people's current communication needs in order to meet this standard. We found that information was not available in easy read pictorial formats that staff told us had been used in the past. One member of staff told us the service had previously used pictorial cards to support one person in their communication but they was no longer used and there was not a current communication plan. This meant there was a risk that people received care that did not meet their communication needs or fully support them to understand information.

People received personalised care because permanent staff that worked in the service were aware of people's needs. This enabled staff to know people and understand their needs and how they liked to be supported. For example, staff were aware of people's support and health needs, and interests. Staff told us that care plans needed to be updated as people's needs had changed. One member of staff told us, "Care plans don't reflect people's needs". For one person the care provided by staff was different to what was recorded in their care plan. Staff now supported the person differently to manage behaviours that challenge. The care plan had not been updated. For another person, their care plan said that staff should follow the person's communication plan. This was not available in the person's care records.

There was no established system for recording, handling and responding to complaints. Two relatives raised concerns with us that they did not always receive a timely response when they raised concerns with the manager. One relative told us, "Issues that I bring up don't seem to be addressed. Communication is falling down". They gave us permission to share their concerns with the nominated individual who told us they would respond to the relative. Staff told us they felt comfortable speaking to the manager if they had any concerns. There were no records of complaints raised in the service and no system in place to store and monitor complaints. The nominated individual told us they would take action to address this. There was a complaints policy in place but information provided to people and displayed in the home required updating. The nominated individual told us they would arrange for this to happen and for it to be circulated to people and relatives.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Staff supported people to engage in a wide range of activities and interests. People had a busy weekly programme of activities which including regular scheduled activities as well as ad hoc sessions where people chose what they wanted to do. We saw the activities included those relating to daily living skills, such as food shopping, as well as leisure activities.

People were provided with opportunities to feedback to the service. Weekly house meetings took place where people came together and discussed the week ahead, planned the following week's menu and were asked how they found their care and if they had any concerns. We saw that feedback about meal choices had been incorporated in the menu planner going forward. One person told us about a meal they enjoyed that was on the menu. One member of staff told us people had requested to go bowling each week. This had been arranged and was enjoyed by people that lived at Touchwood.

People living at Touchwood were not receiving end of life care. Therefore, we did not review arrangements to support people at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

The service had not had a registered manager in place since 14 October 2016. This is a requirement of the provider's registration. We served a fixed penalty notice due to this failure to comply with this condition of registration.

Improvements were required to the monitoring systems within the service and the provider's governance. The quality director told us there were not established systems or checks for the manager to follow to monitor the service. The quality director told us that a new auditing system was being put together and that this system included monthly and six-monthly audits to be completed by the home manager. Audits covered areas such as infection control, incident and accident monitoring, care and staff records. The system in place to monitor incidents was not effective to ensure adequate governance and to ensure people received safe care. Staff told us they were not aware of what checks and audits were carried out in the home by the manager or other staff.

Improvements were required to ensure complete and contemporaneous records were maintained in respect of each service user and the management of the service. The quality manager told us they had carried out a quality monitoring visit in March 2018 and had identified that care records required updating. However not all identified actions had been completed within the timescales to ensure these records were up to date. For example, care plans, health action plans, communication plans and hospital passports still required updating. Other areas were also outstanding such as identifying communication methods for one person to aid communication.

Improvements were also required to ensure records were stored securely in relation to each service user and the management of the service. Records relating to service user's confidential information were not always stored securely and records relating to the service were not stored to allow appropriate oversight and review.

Improvements were required to how the service was managed and arrangements for accountability and delegation of management tasks. The manager was employed to work across two services and the home did not have arrangements for a shift leader or deputy in the manager's absence. Two relatives raised concerns with us that they did not always know who was in charge in the manager's absence. One relative told us, "I don't know who is in charge. You might talk to one member of staff but they don't have authority to guide the rest of the team". Two staff also raised concerns about the management arrangements when the manager was not there. One member of staff told us, "I think it should be managed better. We need a deputy or assistant manager". Another member of staff told us, "[The manager] is doing well but they would benefit from a deputy or a couple of senior care workers to take on some work".

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

Improvements were required to how CQC were notified about certain changes, events and incidents that affect their service or the people who use it. During the inspection we found that there were two

safeguarding concerns that had been responded to and a flood that affected the running of the service which we should have been notified about. The safeguarding concerns had been responded to and actions had been taken by the provider to ensure people's safety but the registered person had not notified CQC as required.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009 (part 4).

Staff spoke positively about the manager's approach. Comments included, "[The manager] is fab, very supportive" and "[The manager] listens and we all work together". Staff also spoke positively about the culture in the home as being person centred and led by people's needs. One member of staff told us, "The way it is run for the guys is good". Another member of staff told us the team worked together to meet people's needs and to keep to people's routines. Staff were all aware of the importance of people's routines, preferences and respected that they worked within people's homes. Staff told us they felt listened to by the current manager and felt involved in some aspects of the service. For example, staff told us they had attended a recent staff meeting.

Two people's relatives told us that they had not always felt engaged and involved in the service. Concerns shared with us included deterioration in communication with the management team over the last twelve months and lack of involvement in the reviews of care provided to their relative. All relatives however spoke highly of the staff team and the care provided. The provider shared with us the survey results from feedback obtained in 2017 from people and relatives about the care provided. The feedback was positive at this time. The provider told us that they were going to send out feedback surveys to people, relatives and stakeholders to obtain current feedback.

The service worked in partnership with other organisations to support people to access services in the community and pursue interests, such as sports clubs.

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 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications that were required by the Commission were not made. Regulation 18 (1) (2) (a) (e) of the Health and Social Care Act 2008 (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had not ensured that an accessible system for identifying, receiving, recording and handling and responding to complaints by service users or other persons in relation to the carrying on of the regulated activity was in place. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not taken effective action to assess, monitor and improve the quality of the service provided. Accurate, complete and contemporaneous records were not being kept in respect of each service user. Regulation 17 (2) (a) (c)