Precious Homes Support Limited

Chandos Road

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 August 2017 and was announced. The provider was given a few days notice as we needed to be sure the registered manager would be available during the inspection.

Chandos Road is a care home for people with acquired brain injuries. At the time of our inspection 7 people were living in the home. This was the home's first inspection under this provider.

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 service completed thorough needs assessments with people and their relatives. However, the care plans and risk assessments that were developed failed to reflect people's preferences or address risks. Care plans lacked detail and records showed staff meetings were used to plan people's care rather than individual reviews or meetings. People's needs with regard to their understanding of English were not met.

Records of incidents showed staff did not always follow guidance in how they responded to people in crisis. Staff were knowledgeable about the different types of abuse people might be vulnerable to and records showed the service escalated concerns in an appropriate way.

People and staff told us there were enough staff on duty. The service had not followed best practice in how it recruited staff.

People were supported to take medicines by staff. Medicines were managed in a safe way that ensured people took their medicines as prescribed. People were supported to be as independent as possible with their medicines.

People living in the home had a range of complex needs. Their support was not based on best practice. Staff had not received the training they needed to meet people's needs.

People indicated their consent to their care by signing their care plans. Where people lacked capacity to consent to their care appropriate Deprivation of Liberty Safeguard authorisations had been obtained. Care plans contained information about how to facilitate people's ability to make their own decisions.

People told us they liked the food. People were able to choose their meals and dietary preferences were known and respected by staff.

People told us staff supported them to attend healthcare appointments when they needed. Staff maintained clear records relating to people's health appointments so information was shared appropriately

with staff.

People and staff had developed strong, caring relationships with each other. People told us staff respected their privacy. People were supported to maintain links with their past and relationships with family members and friends were supported.

The home had a robust complaints policy and records showed complaints were responded to appropriately and in a timely manner.

People and staff spoke highly of the registered manager. Observations showed people and staff interacted with each other and the registered manager easily throughout the inspection. The person centred values of the organisation were reflected in staff meeting records.

The quality assurance systems had failed to identify and address issues with the quality and the safety of the service.

We found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in respect of safe care and treatment, good governance, person-centred care and staffing. We have made a recommendation about recruitment practice. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe. Risks to people had not been appropriately identified or addressed.

Records of staff recruitment had not been properly maintained. The service had not followed best practice guidance in its recruitment processes.

People told us they felt safe. Staff were knowledgeable about different types of abuse and knew how to protect people from abuse.

Medicines were managed in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not received training needed to meet people's specific needs.

Staff received regular supervision from the registered manager to support them in their role.

People consented to their care. Where people lacked capacity to consent to their care the service followed legislation and guidance.

People told us they liked the food and records showed people were supported to eat a varied diet.

People were supported to access healthcare services when required.

Is the service caring?

Good

The service was caring. People and staff had developed strong, caring relationships with each other.

Staff spoke about the people they supported with kindness and compassion.

People were supported with their relationships with their families and links with their past were maintained

People told us they felt they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans did not reflect people's preferences and did not contain enough information to ensure people were supported in line with their needs and preferences.

People were supported with a range of activities but the support they needed to engage with activities was not always recorded in care plans.

The service had a robust complaints procedure and complaints were dealt with in an appropriate manner.

Is the service well-led?

Requires Improvement

The service was not always effective. Quality assurance checks and audits had not identified or addressed issues with the quality and safety of the service.

The provider had not taken action when the home had raised issues of maintenance with them.

The provider stated on their website they were able to provide services with specialist support but this was not available at this service.

People and staff spoke highly of the manager.

The atmosphere in the home was positive and person-centred.

Chandos Road

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.

The inspection was carried out by one inspector on 2 and 3 August 2017. The provider was given a few days notice of the inspection. This was because we needed to ensure the registered manager would be available during the inspection.

Before the inspection we reviewed the information we already held about the service. This included reviewing the documents they had submitted when they registered the home in March 2016 and notifications they had submitted to us. We sought feedback from the local authority and local Healthwatch.

During the inspection we spoke with two people who lived in the home and three members of staff including the registered manager and two support workers. We reviewed three people's care files including needs and risk assessments, support plans, reviews, and medicines records. We reviewed three staff files including recruitment, supervision and training records. We also reviewed various meeting minutes, policy documents, audits and reports relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

Care files contained information on the risks people faced while living in the home and while accessing the community. However, serious risks to people and others had not been appropriately identified or addressed by the provider. For example, one person had previously disclosed they may behave in a way that caused serious harm to others. Their open disclosure of this behaviour put them at risk of harm from others. This had not been included in this person's risk assessments or identified as a risk by the service.

Another person had previously been convicted of an offense that put others at risk of harm but this had not been identified as a risk and there were no plans in place to mitigate the risk of re-offending. The registered manager described the measures that were in place to mitigate these risks, but they were not sufficient and had not been formally captured in a risk assessment that was shared with staff.

Risk assessments in place for risks that had been identified were not sufficient to ensure risks were appropriately mitigated. For example, one person was identified as being at high risk of falls. The risk assessment related only to the risk of falls in the home, when the falls had taken place when the person had been accessing the community independently. Their risk assessment had not been reviewed or amended following a fall.

Another person was identified as presenting a risk to others due to their behaviours. The plan in place to address this risk recognised that miscommunication was a major trigger for these behaviours. The risk assessments and guidance repeatedly stated that a member of staff who spoke this person's first language should be sought to aid communication and de-escalate incidents. However, only one member of staff spoke this language and they were not available all the time. There were no alternative options described in the risk assessments.

A third person was also identified as being at risk due to behaviours that could harm themselves or others. There were detailed plans and guidance in place for staff with a script for them to follow to help de-escalate incidents. However, this plan also relied on the single member of staff who could speak the languages primarily used by this person. Incident records showed that although staff attempted to de-escalate incidents, they were not following the guidance in place.

In addition, people living in the home had health conditions including epilepsy and diabetes which meant they were at risk of health related emergencies. There were no risk assessments in place or guidance for staff on how to respond in the event of a seizure, or diabetic emergency. This meant the measures in place to identify and mitigate risks were insufficient to ensure people received safe care.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment records showed the provider carried out checks on people's criminal records, identity and right to work to ensure they were suitable to work in a care setting. The provider's policy stated that potential

employees should provide two external references. However, records showed this had not been done. For example, one person's file contained only one character reference and the name of the person who supplied this reference was different from the name of the referee supplied in the application form. There was no record to explain why a different referee had been used and no detail of the referee's relationship with the applicant. Another person's file contained no references and only contained confirmation they had completed a qualification. After the inspection the provider submitted records that showed references had been collected in line with their policy. These had not been available during the inspection as they were stored elsewhere.

The provider's recruitment policy stated the interview process should involve a panel of managers, recruitment staff and a person who was going to receive a service. The interview records reviewed did not show a panel had interviewed people as only one name was on the interview record. In addition, the interview records did not show how the provider had evaluated people's responses in order to judge whether they were suitable to work in the service. For example, one staff member's record was marked as "above average" in all areas but there was no record of their answers to show how that judgement was made. After the inspection the provider submitted interview records which showed how the decision to appoint staff had been made. The providers records had not been appropriately maintained and were not always clear.

We recommend the service seeks and follows best practice guidance from a reputable source regarding staff recruitment practice.

People told us they felt safe with staff and would be able to tell staff if they felt unsafe. One person said, "Staff would listen if I told them [I felt unsafe]." Staff knew about different types of abuse people living in the home might be vulnerable to and were confident about what action they would take if they had a concern. One member of staff explained, "I'd talk to the manager. If the manager doesn't do anything I'll take it to senior managers. If the company doesn't do anything then it's a whistleblowing and I'll tell the local authority or CQC." Records showed staff completed an online training course on the principles of safeguarding and protection.

Records showed the service had taken appropriate action in response to incidents and allegations of abuse. The registered manager had made appropriate referrals to the local authority safeguarding teams and taken action to ensure people's immediate safety. This meant people were protected from abuse.

Staff supported people with their finances and held money on their behalf. The home had a secure system where money was counted daily and stored in tamper proof wallets when not being accessed. Staff members recorded people's financial transactions in a bound book and the manager checked the balances and completed audits on a weekly basis. Records and balances were checked and found to be correct. This meant people were protected from the risk of financial abuse in the home.

People and staff told us they thought there were enough staff on duty in the home. One member of staff told us, "We have enough staff. It means we can go out with people when they want." Another member of staff said, "There are enough staff to meet people's needs. Maybe if there were more staff we could do more activities. It's logical, the more staff on duty the more activities we can do. [Manager] brings in more staff if we need it. They authorise more staff." Records of staff on duty were checked and showed a minimum of two staff on duty throughout the day, with the registered manager providing additional support when required.

People told us staff helped them to take their medicines. Records showed people were assessed to see if

they were able to self-administer their medicines and if they were able to do so this was facilitated. Staff were confident in discussions of how they would respond to a medicines error and how they supported people to take their medicines. People who needed support to take their medicines had plans in place which described their medicines, their purpose, how they were supposed to take them and any adverse reactions to be aware of. Medicines plans included details of any known medicines allergies people had. It was noted that medicines lists in health documents were not always kept up to date as dosages and medicines changed. The registered manager updated medicines lists in key documents in response to this feedback.

Medicines were stored in a locked medicines cupboard in a locked room. Records showed staff monitored the temperature in the room, and of medicines fridges to ensure medicines were stored in a safe way. There were signs on display to remind staff to take measures to ensure the medicines room did not become too hot. The medicines records showed people were supported to take their medicines as prescribed.

One person was supported to take their medicines with them when they accessed the community so they would not miss any medicines. This involved dispensing the medicines into a secondary container. This is not considered good practice. After the inspection the registered manager sent us a robust risk assessment which contained detailed instructions to ensure risks of secondary dispensing were minimised while the person's independence with their medicines was supported.

Staff completed daily counts of the medicines in stock, and the manager competed weekly and monthly audits to check the correct amount of medicines were in the service. Records showed that where medicines errors were identified the service took appropriate action to investigate incidents and retrain staff to minimise the risk of future errors.

People were prescribed medicines on an 'as needed' basis. Although there were detailed instructions for staff to follow regarding the circumstances in which these should be offered and administered, these had not been reviewed or updated since May 2016. The registered manager sent us records to show these were reviewed after the inspection.

Requires Improvement

Is the service effective?

Our findings

Records showed that staff received training in areas relating to care, including administering medicines, infection control, equality and diversity, health and safety, fire safety and first aid. However, people living in the home had a range of complex needs which required specialist support from skilled staff. Staff had not had training to meet these needs. For example, staff had not received the providers managing actual and potential aggression (MAPA) training for supporting people who presented with behaviours that could be violent. This was despite several people living in the home behaving in this way. Only three out of the eight staff working at the service had received training in positive behaviour support. This is a recognised approach to de-escalating and supporting people who can behave in a way that is harmful to themselves or others. None of the staff had received training in epilepsy despite several people living in the home being diagnosed with epilepsy. This was reflected in the answers given by staff when asked if someone had a specific type of seizure. One staff member said, "What's that?" In addition, none of staff had received training in diabetes despite one person living in the home being an insulin dependent diabetic.

The above issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us, and records confirmed, they received monthly supervision from the registered manager. A staff member told us, "Supervision is about the service users, what to improve or change. It's about their needs. We also talk about my areas, where I might need help, or what their [provider's] expectations are." Records showed supervisions were used to discuss people's needs, as well as to discuss performance and attendance issues.

People told us that new staff were supported when they started their role. One person said, "They seem to settle in quite quickly." Records showed staff were supported to complete an induction to the service and where they were new to working in a care setting they completed the Care Certificate. The Care Certificate is a nationally recognised qualification that provides staff with the fundamental knowledge required to work in a care setting. New staff completed a probationary period before being confirmed in role. Records showed staff met with the registered manager regularly during their probation period to monitor and evaluate their performance. This meant staff were supported in their roles.

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

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

Some people lacked capacity to consent to their care, and their care was considered restrictive appropriate applications to deprive them of their liberty had been made. Records showed where people were subject to restrictions, such as continuous supervision, this had been appropriately authorised. People who had capacity to consent to their care had indicated this by signing their care plans.

Care plans contained a section relating to decision making, which included details of how people communicated their decisions and how staff should support them to make their own decisions. For example, one person's care plan recorded they were most likely to have capacity to make a decision when they were presented with the information in their first language and given time to consider it.

Staff demonstrated they understood that people's capacity to make decisions could fluctuate. One member of staff told us, "Most of the guys have capacity, but will lack in certain areas. There's a best interests process if we think they can't weigh up the decision. If they want to go out and lack capacity, we don't stop them, but we will go with them. One person has a GPS tracker so they can go out by themselves but we know they are safe." This meant the service was seeking consent in line with legislation and guidance and people were supported in the least restrictive way possible.

People told us they liked the food in the home. One person said, "There's lots of nice food." There was a high level summary of people's key dietary preferences on the noticeboard in the kitchen. This included information such as religious needs and foods people did not eat. House meeting records showed people discussed the menu options and made meal suggestions. Staff had a good knowledge of people's dietary needs and preferences, telling us easily what people's favourite foods were. However, this was not recorded in people's care plans so was not available for new staff or agency staff who did not know people well. Records of care showed people were supported to eat a varied diet with healthy options encouraged and available.

People told us staff supported them to access healthcare services. One person said, "Staff help me when I'm unwell." Another person told us, "Staff help me to do what the doctor says." Care files contained health action plans and health passports. These were documents that contained information about people's health and meant all the information about people's health was available for health professionals involved in their care. Staff made detailed records of people's health appointments which included the advice of healthcare professionals. Handover records demonstrated this information was shared across the staff team to ensure staff were up to date in people's healthcare needs. Where people's health conditions required regular monitoring to take place records showed staff supported people with this. For example, one person needed to have their blood pressure checked each week.

Records showed when there were changes in people's health needs, or there were concerns about their physical health staff made appropriate referrals to healthcare services. However, one person's referral information indicated they suffered from a mental health condition. This was not included in their health related care plans and was not included as a support need. This was despite the person taking regular medicines for this condition. This meant there was a risk mental health needs were not met in the same way physical health needs were.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "I like living here. I've made it my home. The staff are friendly." Staff spoke about people with kindness and compassion recognising their individual differences. Staff demonstrated sensitivity about the changes in people's circumstances that had led them to live at the home. One member of staff explained, "I get to know people by working with them, the way they interact. I treat people how I would like to be treated. In this life anything can happen and working here reminds you of that."

Care plans contained as much information as the home was able to gather about people's history through discussions with people and their families. They included information about people's education, previous employment and interests prior to moving to the home. For example, one person's care plan contained details of their political views and favourite discussion topics for conversation.

Care plans contained details of people's family relationships, however, family member's names were not consistently included in documents. For example, one person's family members were all named, but in another person's plan only one relative was named but it was noted they had many other relatives they had regular contact with. People told us they were supported to stay in touch with their relatives. One person said, "Staff help me stay in touch with my family." Records showed people were supported to speak to relatives on the phone, and visit them where this was possible.

Both staff and people who lived in the service had documents in their files about their interests, values and cultures. These were described as support matching documents and people's records showed the values, skills and communication style they looked for in staff. These documents provided a one page profile which provided a starting point for staff to get to know people.

Care plans contained details of people's religious beliefs. People were supported to practice their faith if they chose to do so. Staff recognised that people's faith was important to them. One member of staff said, "They are religious, it affects their food, they have different types of food." However, information for staff about how to support people with matters relating to their faith was limited. For example, one person's faith was very important to them and they attended their place of worship independently. Their care plan stated, "[Person] follows religion daily in all aspects of their life." However, there was no information for staff about what that meant to ensure they facilitated this. There was no information for staff about religious festivals so they could support the person to celebrate these. The registered manager told us they were aware of the festivals and supported the person appropriately, but this was not captured in the records. This meant there was a risk people were not consistently supported to practice their faith.

People told us staff respected their privacy. One person said, "My bedroom is my space. Staff knock before they come in. All the staff all the time, they're very polite." Although it was not captured in care plans, staff recognised that people living in the home had sexual needs, and should be given the support they needed to express these appropriately. One member of staff explained, "People here have sexual needs, of course they do, they're human beings. People can have private time, on their own or with their partners, in the

rooms. We respect that." This meant people were treated with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

Records showed people and their relatives were involved in a comprehensive assessment of their needs before they moved into the home. This was reflected in the recording of people's views in the assessment which detailed their aspirations for support and preferences for how they wished to be treated by staff. The assessment was used to form the basis of the support plan. Support plans did not reflect the detail of information collected in the assessment, and in some cases contained contradictory information. For example, one person's relative had provided detailed information about their preferences for having a bath but the care plan stated the person should be supported to have a shower on a daily basis.

Care plans contained limited detail on the nature of support staff should provide. For example, one care plan stated, "He is not able to shave independently and cannot cut his own nails." There was no further information for staff on what this meant in terms of the support provided to this person. Another person had the goal of improving their English included in their care plan. The care plan stated, "[Registered manager] will be working with [person] to learn English words with meanings in [first language]." There was no further information for staff other than the registered manager to help them support the person with this goal. This person had to attend regular appointments at a government office. However, there was no detail in the care plan documentation about why this person had to attend and what support they needed in attending or understanding these appointments. This meant there was a risk that people did not receive the support they needed as it was not captured in their care plans.

People living in the home experienced memory difficulties as a result of their conditions. Care plans included goals to work on improving people's memories. One person had sessions called "Cognitive Exercises" on their daily timetable. However, there was no detail in the care plan about how to facilitate these exercises and no record that these had been developed and recommended by an appropriate healthcare professional. The registered manager explained he had developed these exercises based on knowledge acquired through their previous study and showed a video of these exercises being completed. The video showed a person being encouraged to remember what they had eaten for breakfast that morning using the association of their breakfast bowl.

After the inspection we sought advice from a national organisation that specialises in providing support to people with brain injury about these exercises. They advised that it was good the home was attempting to support people with improving recall but advised such exercises should be based on specific and unique aspects of the day, rather than general aspects that could be known or logically deduced rather than remembered. They also advised a more standardised approach would be more likely to be effective. The support provided was not based on professional advice or best practice in the sector.

Two people living in the home spoke English as an additional language. Both of their care profiles stated the best match for staff for them would be staff who spoke their first languages. Although the registered manager was able to speak their languages, none of the other staff were able to. Throughout both the care plans it was clearly recorded that the best way to support people to achieve their goals was through the use of clear communication in their main language. The lack of staff who were able to meet their language

needs meant there was a reliance on the registered manager and a risk that people's needs were not met when they were not available.

One person's care plan had established the amount of time it would take to support them with different aspects of their care. For example, it had been recorded they would need 3 hours support a week to increase their independence with meal preparation. There were handwritten amendments to this document which showed the amount of hours had been reduced. The registered manager told us this was done following a review by a social worker and a reduction in the package funded. Although they were able to produce email correspondence which showed reductions had been agreed, there was no record of the meeting and the care plan had not been amended. It was not clear how the service had decided they could meet the person's needs with the reduced package.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff reviewed people's progress on a weekly and monthly basis. These records showed people were working towards smaller goals, such as increasing the amount of exercise they did, or completing a domestic task. However, it was not recorded in their care plans what the specific goals or focus was for a particular month. The registered manager told us the goals were established and communicated with staff through staff meetings. Staff meeting records showed this was the case, and there was detailed discussion about how to provide support and specific goals during these meetings. The registered manager recognised that new staff, or agency workers would not be reading staff meeting minutes to obtain information about how to support people and this information should be captured in the care plan.

People told us they were supported with activities. One person said, "They support me to try new things." Observations during the inspection showed people were supported to access the community and participate in household activities. House meeting records showed people were asked what activities they would like to take part in and records of care showed these were completed. However, people's regular activities were not always included in their support plans or activities timetables. For example, one person visited relatives with staff support on a daily basis but this was not included in their activity timetable or care plan. This meant there was a risk this support would not take place as it was not scheduled.

The home had a complaints policy which included details of the expected timescale for complaint resolution and how complainants could escalate concerns if they were not happy with the response. Records showed complaints were responded to in line with this policy and escalated appropriately. The complaints records included an evaluation of the experience of the complainant to ensure they were happy with the response and actions to ensure any issues did not recur. This meant the service responded to complaints appropriately.

Requires Improvement

Is the service well-led?

Our findings

The provider had established a system of audits and checks. These included an annual external audit of the service in line with the key lines of enquiry from inspection and quarterly audits by another manager from the provider. Although the external audit had identified issues with the quality and detail of care plans in February 2017 these had not been addressed by the service as care plans still lacked detail of the nature of support to be provided. The internal audits had not identified the issues with the quality and safety of the service identified during the inspection. None of the audits had identified or addressed that risks had not been appropriately identified or addressed.

The registered manager completed a range of audits within the service, including weekly audits of people's finances, medicines, as well as the environment of the home. These audits had not identified that the cupboard doors in the shared bathroom were in need of repair. They had not identified that the carpets in the hallways and stairs were dirty and stained. The registered manager told us a deep clean of the carpets had been scheduled.

Staff at the home completed health and safety checks, including fridge and freezer temperatures, food temperatures and hot water temperatures. The hot water temperature checks showed that each measurement taken in July 2017 had been above the stated maximum of 42 degrees. The records were not accurate, as one tap was recorded as being 122 degrees. It is not possible for a hot water tap to flow at that temperature as it would be steam. The registered manager told us they adjusted the settings on the boiler after each reading that was above 42 degrees and retested the water temperature. However, this was not recorded and the recurrence of water temperatures above a safe level showed this was not an effective way to ensure safe water temperatures as temperatures did not remain at a safe level. This meant measures in place to ensure the safety of people who used the service had not been effective.

The registered manager completed maintenance audits which escalated maintenance concerns to the provider. These referred to a fire safety audit completed in October 2016 which identified concerns about the seals on fire doors and the use of a key to lock the front door. Although the home had escalated this concern each month since then, the provider had not taken action to address safety concerns at the home. This meant people were at risk of harm.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had completed an annual survey to collection information from people and their relatives about the quality of the service. After the inspection the provider submitted a report and analysis of the responses. The analysis found no actions were required other than continuing to support people according to their care plans.

The provider's website stated a multi-disciplinary team was available to all the services in the group in order to provide specialist support for people in crisis or with complex needs. People living in the home had

specialist needs, and the increase in incidents for one person indicated the service required additional support in order to meet their needs. However, the home had not utilised the in-house multi-disciplinary team to support people's care. The registered manager told us they utilised local healthcare services as the provider's specialists were based in a different area of the country and could not respond in a timely way. This meant people were not receiving the specialist input the provider stated was available to them.

People and staff spoke highly about the registered manager. One person said, "[Registered manager] tries hard." A staff member told us, "I like [registered manager]. He really works hard. Your problem is his problem. We all have a good relationship with the manager. You feel like coming to work." Another member of staff said, "[Registered manager] is good. He listens. We can talk about things. We try new ideas. He is positive, if we think something will be better for the guys we will give it a try. He knows lots about the guys we support." The registered manager knew the people in the home very well, and was able to provide details about people's needs and preferences that had not been captured in the records. Observations during the inspection showed people and staff interacted positively with the registered manager.

The provider's values of person centred care focussed on the aspirations of people receiving a service and were reflected in the staff meeting minutes. These showed detailed discussions of people and their needs and wishes. The values were also reflected in the conversations with staff which focussed on ensuring individuals were offered choice and as much control as possible. One member of staff said, "Before [person] didn't go out. He was miserable. We worked to offer him choices, and supported him with confidence. We built it up slowly and now he goes out, at least twice a week. He's much happier now."

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 Care plans did not reflect people's assessed needs or preferences. There was insufficient detail to ensure people received person-centred care. Regulation 9(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Issues with the quality and safety of the service had not been identified or addressed by the provider. Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been appropriately identified or addressed by the service. Regulation 12(1)(2)(a)(b)

The enforcement action we took:

We issued a warning notice to the registered manager and the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Issues with the quality and safety of the service had not been identified or addressed by the provider. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We issued a warning notice to the registered manager and the provider.